ANSWER GUIDE

SELF-ASSESSMENT IN Clinical Psychiatry

ONLINE

A CME Companion to
The American Psychiatric Publishing Textbook of Clinical Psychiatry, Fourth Edition

Donald M. Hilty, M.D.
James A. Bourgeois, O.D., M.D.
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The American Board of Psychiatry and Neurology (ABPN)
has reviewed the
APPI Self-Assessments CME Program
and has approved this product as part of a
comprehensive lifelong learning program,
which is mandated by the
American Board of Medical Specialties
as a necessary component of maintenance of certification.

ABPN approval is time limited to 3 years for each
individual Self-Assessment CME course.

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Introduction

Self-Assessment in Clinical Psychiatry is a self-paced, online examination that allows you to evaluate your mastery of the subject matter as you progress through *The American Psychiatric Publishing Textbook of Clinical Psychiatry*, Fourth Edition. The exam was developed by leaders in the field of clinical psychiatry, including the *Textbook* volume editors—Donald M. Hilty, M.D., James A. Bourgeois, O.D., M.D., Robert E. Hales, M.D., M.B.A., and Stuart C. Yudofsky, M.D. (For more information about the *Textbook*, including to purchase it, please go to www.appi.org.)

The program provides an easy-to-access and individualized opportunity to gain and assess knowledge of clinical psychiatry, ideally to be undertaken by psychiatrists and residents as part of a comprehensive lifelong learning program in psychiatry. It provides a specific educational opportunity for candidates preparing for certification and recertification examinations.

By participating in the Self-Assessment in Clinical Psychiatry program, you will have the opportunity to

- Enhance knowledge of clinical psychiatry
- Improve clinical decision making and patient care
- Test and assess your clinical knowledge and decision-making skills
- Prepare for certification and recertification
- Practice answering board-like questions
- Earn up to 20 CME category 1 credit hours

Participants earn continuing medical education (CME) credit hours for reviewing the *Textbook*, assessing their retention of the clinical content of the *Textbook* by taking the self-assessment exam, and further increasing their clinical knowledge by reviewing the rationale for the correct answers. The Answer Guide references relevant text, tables, and figures (including the page number) in the *Textbook* to allow quick access to needed information. Each answer is accompanied by a discussion that addresses not only the correct response but also explains why other responses are not correct.

This self-assessment exam represents further efforts by American Psychiatric Publishing, Inc. (APPI), and the American Psychiatric Association to provide practicing psychiatrists and residents with opportunities for lifelong learning and self-assessment of knowledge that meet evolving certification and recertification requirements of the American Board of Psychiatry and Neurology (ABPN). In addition to developing online self-assessments and companion textbooks for each major subspecialty in psychiatry, APPI has created the Core Competencies series—a series of books that explicitly address the six core areas of competency needed in medical practice as outlined by the Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties. Included in the series are a book authored by executives of ABPN that details the core competencies, a book by a training director about implementing a training and evaluation program that incorporates core competencies, and books covering each of the five core competencies in psychotherapy. (Go to www.appi.org for more information about the Core Competencies series.)

Taking the Self-Assessment Exam

Format of the Exam and Scoring

The self-assessment exam is made up of 256 questions divided into 40 individual quizzes of 5 to 10 questions each that correspond to chapters in *The American Psychiatric Publishing Textbook of Clinical Psychiatry*, Fourth Edition. (To purchase a print copy of the textbook, please go to www.appi.org.) You can answer questions at your own pace and save your progress after each quiz.

After you've completed each short quiz, your score is calculated instantly and the Answer Guide for the quiz is shown. For each question, your answer and the correct answer are highlighted and are accompanied by a discussion with supporting references that addresses not only the correct response but also explains why other responses are not correct. The Answer Guide also references relevant text, tables, and figures (including the page number) in the *Textbook* to allow quick access to needed information.

You can then move on to the next quiz in chapter order, return to the contents listing and choose any other chapter, or log out and continue the exam later. A summary page ("My CME") details your progress through the individual quizzes and updates your cumulative score as you go.

Even after you've completed all quizzes, you retain access to your responses and the Answer Guide for the life of the course.

Printable Copy

To maximize your studying options, downloadable and printable copies of the entire exam and the Answer Guide (questions and answers with supporting rationale and references) are available in Adobe's Portable Document Format (PDF). As soon as you purchase the exam, you'll have access to a PDF file containing the questions only; after completing the exam, you'll be given access to a PDF file containing the questions and the Answer Guide.

Please note that scoring of the exam and CME credit are available only if you take the exam online.

CME Credits

The American Psychiatric Association (APA) designates this educational activity for a maximum of 20 category 1 credits toward the American Medical Association's Physician's Recognition Award and for APA's CME requirement. You should claim only those credit hours actually spent in the activity.

CME credits are awarded when the entire exam (all 40 quizzes) is completed. No minimum percentage of correct answers is required for CME credit to be granted. CME credits must be claimed by the program end date of December 1, 2008.

Evaluation and CME Certificate

After completing all quizzes, you'll have the opportunity to evaluate the exam online. You'll also be able to print an official Certificate of Completion from APA that documents your participation in the course and the number of CME credits awarded. This printable certificate in the form of a web page is all the documentation that you'll need.

Page numbers and tables and figures referenced by number refer to
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Take the Self-Assessment exam online
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CME Accreditation

Begin date: December 1, 2003
End date: December 1, 2008

Estimated time to complete: 20 hours

The American Psychiatric Association (APA) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

APA designates this educational activity for a maximum of 20 category 1 credits toward the American Medical Association's Physician's Recognition Award and for APA's CME requirement. Each physician should claim only those credits that he/she actually spent in the activity.

Educational Objectives

- To improve physician knowledge about the clinical practice of psychiatry as presented in *The American Psychiatric Publishing Textbook of Clinical Psychiatry*, Fourth Edition
- To improve clinical decision making and patient care by increasing physicians' knowledge about clinical psychiatry
- To test and assess clinical knowledge and decision-making skills

Statement of Intent

The Self-Assessment in Clinical Psychiatry exam is intended to assist psychiatrists in keeping abreast of new knowledge and scientific developments in the field of psychiatry and in maintaining a lifelong learning program that will fulfill the needs of self-assessment and ongoing Maintenance of Certification. This self-assessment exam may also be useful in studying for other examinations, such as the General Psychiatry Recertification Examination of the American Board of Psychiatry and Neurology (ABPN).

Important note: Although it is anticipated that participation in this self-assessment examination will be of assistance to psychiatrists taking other examinations, no guarantee concerning actual performance on other examinations is intended or implied.

ABPN Approval

The American Board of Psychiatry and Neurology (ABPN) has reviewed Self-Assessment in Clinical Psychiatry and has approved this product as part of a comprehensive lifelong learning program, which is mandated by the American Board of Medical Specialties as a necessary component of maintenance of certification.

ABPN approval is time limited to 3 years for each individual Self-Assessment CME course.

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CHAPTER 1

Genetics

Select the single best response for each question.

1.1 Some clinical genetic diseases in humans are disorders transmitted in patterns that can be predicted from knowledge of how genetic information is transmitted to offspring during meiosis (Mendel's Law). Which of the following statements is true regarding psychiatric disorders?

A. They have etiological homogeneity.
B. They have well-defined phenotypes.
C. They have reproducibly associated chromosomal rearrangement syndromes.
D. They have clear-cut inheritance patterns.
E. They will be easier to understand based on the findings of the Human Genome Project.

The correct response is option E (pp. 3–4). The fact that psychiatric disorders lack etiological homogeneity, well-defined (or, for that matter, stable) phenotypes, and reproducibly associated chromosomal rearrangement syndromes makes finding the disease genes considerably more difficult. Help for this difficulty is expected to come from the Human Genome Project.

1.2 Findings of the Human Genome Project

A. Have led to biological tests for the presence or absence of a clinical disorder.
B. Imply that genetic linkage studies will be less difficult as a result of the diagnostic precision in our field.
C. Have not included genes responsible for complex psychiatric disorders.
D. Include a mutation rate in males that is twice as high as that in females.
E. Include discovery of more than 200,000 total genes, more than was expected.

The correct response is option D (p. 4). A major finding of the draft genome sequence that has direct relevance to psychiatric genetics is that the mutation rate is twice as high in males as in females.

1.3 Which of the following personality disorders shows evidence of genetic transmission, on the basis of family risk, twin, and molecular studies?

A. Antisocial.
B. Avoidant.
C. Borderline.
D. Dependent.
E. Schizotypal.

The correct response is option E (p. 6; see Table 1–1). Antisocial, schizotypal, avoidant, and dependent personality disorders all show evidence of genetic transmission in family risk studies, but only schizotypal disorder demonstrates genetic transmission in twin and molecular studies as well. Genetic transmission of borderline personality disorder is supported only by twin studies.

1.4 A methodological limitation of adoption research, in terms of its ability to separate genetic from environmental influences, is the fact that

A. Most children are adopted away at birth.
B. The environment begins at birth.
C. Adopted children cannot be considered a representative sample of the population.
D. Adoptive parents often have as much psychiatric illness as biological parents.
E. A false genetic hypothesis (type I error) has been accepted.

The correct response is option C (p. 9). Because few children are adopted away immediately after birth, usually some familial environmental influences of undetermined significance exist that are difficult to measure. Also, "environment" does not begin at birth; the uterine environment of an affected mother may be significant in the transmission of the illness, which may be examined by comparing the risk to the children of affected mothers with the risk to the children of affected fathers or, in the study of the adoptive and biological relatives of adoptees with a disorder, by comparing the risk to paternal half-siblings with the risk to maternal half-siblings. Another major difficulty stems from the unusual nature of adoptions. The types of parents who give up their children or the circumstances that lead parents to give up their children may alter the representative nature of the adopted sample. Consequently, adopted children cannot be considered representative of the population.

1.5 A 24-year-old woman with no history of medical or psychiatric disorders sought help in the psychiatric outpatient clinic for anxiety related to her mother's cancer treatment. Her mother eventually went into remission, and the patient terminated treatment; however, a few months later she recontacted the clinic, reporting that she had experienced more anxiety while participating in a clinical trial as a healthy subject. The research trial involved administration of cholecystokinin. This woman is at risk for which of the following disorders?

A. Bipolar disorder.
B. Depression.
C. General anxiety disorder.
D. Panic disorder.
E. Posttraumatic stress disorder.

The correct response is option D (p. 31). Individuals with panic disorder are more sensitive to the anxiogenic effects of multiple substances, including cholecystokinin, lactate, and inhaled carbon dioxide.

CHAPTER **2**

Normal Child and Adolescent Development

Select the single best response for each question.

2.1 Sigmund Freud's hierarchy of threats during early childhood are experienced in which of the following sequences?

A. Helplessness, separation, castration anxiety, punishment by guilt.
B. Separation, helplessness, annihilation, castration anxiety.
C. Annihilation, separation, castration anxiety, punishment by guilt.
D. Separation, helplessness, punishment by guilt, castration anxiety.
E. Helplessness, separation, annihilation, punishment by guilt.

The correct response is option A (p. 72). According to Freud's (1926/1959) formulation, *helplessness* is the first signal of danger. *Separation,* occurring somewhere between 7 and 24 months, follows, and then *castration anxiety* (or body integrity anxiety) takes over from the third through the sixth years. Finally, danger of *punishment by guilt* ensues from an internalized value system embodied in the superego, which is an agency of the tripartite mind of the new structural model.

2.2 Rene Spitz's genetic field theory specifies the appearance of three "organizers" in which developmental sequence?

A. Smiling response, separation anxiety, signal for "no."
B. Separation anxiety, stranger response, signal for "no."
C. Stranger response, separation anxiety, signal for "no."
D. Smiling response, stranger response, signal for "no."
E. Smiling response, stranger response, separation anxiety.

The correct response is option D (p. 73). Spitz's (1965) first organizer, the *smiling response,* includes a consistent and repeatable social smile in response to a full face or moving oval with darkened areas representing eyes. This maturational landmark links outside experience and autonomous function, supporting the notion of a regularly responsive internalization en route to what psychoanalysts call *object constancy.*

The next organizer, the *stranger response,* occurs at about 7 months. The child now turns away from the stranger with apprehension, terminating what Anna Freud (1965) has called the period of *need satisfying object.* This second organizer marks the attachment to a specific other. The third organizer, the development of the *signal for no,* then signifies a fully internalized and individuated human toddler who now can undo with a verbal signal. According to Spitz, the toddler is now an agency and center of will separate from the mother.

2.3 Margaret Mahler's separation–individuation subphases are specified in which sequence?

A. Differentiation, object constancy, and practicing.
B. Object constancy, practicing, and differentiation.

C. Object constancy, differentiation, and practicing.
D. Differentiation, practicing, and object constancy.
E. Practicing, differentiation, and object constancy.

The correct response is option D (p. 73). Mahler's separation–individuation theory continues the process of development into the postuterine period, involving the "hatching" of human consciousness, with the toddler as a separate, discrete autonomous agency (Mahler et al. 1975). In Mahlerian terms, the child moves from an autistic to a symbiotic stage in which he or she is initially enmeshed psychologically with the mother as though he or she were not separate from the mother.

The separation–individuation process includes a number of substages that equip the child with various capacities enabling him or her to develop the ego strengths necessary for adaptation. During the *differentiation* subphase, psychological birth occurs under the rubric of hatching, which is characterized by a permanently alert sensorium in which visual and manual examination of the external world become central. Next emerges the *practicing* subphase, which is characterized by increased curiosity. The child now appears as if he or she were omnipotent and as if an internal agency were not dissociated from an external agency. Only with the understanding that the mother is separate, during the next subphase, does the child arrive at what is called *object constancy*. Relative independent action can take place after the child is able to keep a stable mental image of the important caregiver.

2.4 Arnold Gesell's cross-sectional scheme describes the development of behavior across all of the following sectors *except*

A. Motor.
B. Adaptive.
C. Language.
D. Affective.
E. Personal–social.

The correct response is option D (p. 74). Gesell divided behavior into four sectors: motor, adaptive, language, and personal–social. He tracked these behavioral observations over the long period of infancy and described a normative timetable (Gesell and Amatruda 1947).

2.5 John Bowlby's five "components" of attachment behavior (as opposed to responses to separation) include

A. Sucking, protest, clinging, following, smiling.
B. Sucking, clinging, following, crying, smiling.
C. Clinging, sucking, despair, following, smiling.
D. Clinging, grief, despair, following, sucking.
E. Protest, sucking, clinging, following, crying.

The correct response is option B (p. 77). Bowlby (1969, 1973, 1980) described five components of attachment behavior in the infant. Experiences are integrated to create a unified mental representation. The activated reflexes of sucking, clinging, and following have representation in other species, but are also present in the human. Crying and smiling achieve their ends by reciprocal maternal behavior: they bring the mother to the child.

2.6 Lewis and Michelson's structural analysis of emotions refers to

A. Emotional state, expression, and experience.
B. Emotional expression, experience, and reciprocity.
C. Emotional state, experience, and reciprocity.
D. Emotional expression, reciprocity, and mastery.
E. Emotional state, expression, and mastery.

The correct response is option A (p. 83). In the structural analysis of emotions proposed by Lewis and Michelson (1983), *emotional state* refers to internal changes in somatic and/or physiological activity, and *emotional expression* to observable changes in face, body, voice, and activity level that occur when the central nervous system is activated by emotionally salient stimuli. *Emotional experience* refers to the consequences of the cognitive appraisal and interpretation of perceived emotional states and expression.

2.7 The emergence of stranger anxiety is regularly observed by age

A. Younger than 4 months.
B. 4–8 months.
C. 8–12 months.
D. 12–16 months.
E. 16–24 months.

The correct response is option C (p. 84). Although facial expressions of fear begin to be noted at 6 months of age, outright fear in the presence of a stranger is not regularly observed until somewhat later (8–12 months), and even then it is dependent on the situation.

2.8 Ainsworth's "strange situation procedure" is used to assess the quality of attachment. Which of the following describes a securely attached child?

A. Mild protest with mother's departure, seeks mother upon her return, easily placated by mother.
B. Mild protest with mother's departure, no approach to mother upon her return.
C. No protest on mother's departure, no approach to mother upon her return.
D. Marked upset with mother's departure, readily accepts mother's effort to comfort upon her return.
E. Indifference to mother's departure, rejection of mother on her return.

The correct response is option A (p. 85). Ainsworth et al. (1978) developed a research method for assessing the quality of attachment in 12- to 18-month-old children. The strange situation procedure involves a set series of 3-minute separations and reunions with a caregiver and with a stranger in an unfamiliar room. Children who show mild protest following the departure, who seek the mother when she returns, and who are easily placated by her (about two-thirds of a sample of middle-class 1-year-old American children) are considered as the most securely attached. Infants who do not protest maternal departure and who do not approach the mother when she returns (about one-quarter of the sample) are characterized as avoidant. Children who become markedly upset by departure and who resist the mother's efforts to comfort them when she returns (about one-tenth of the sample) are described as resistant or anxiously attached.

2.9 Regarding Offer and Offer's study of adolescent development, the three specified developmental routes are

A. Continuous growth, surgent growth, and tumultuous growth.
B. Tumultuous growth, surgent growth, and early maturational growth.
C. Surgent growth, tumultuous growth, and early maturational growth.
D. Continuous growth, erratic growth, and surgent growth.
E. Tumultuous growth, early maturational growth, and continuous growth.

The correct response is option A (p. 91). Offer and Offer (1975) found three developmental routes, which they designated as continuous growth (23% of the sample), surgent growth (35%), and tumultuous growth (21%).

2.10 Common developmental themes of adolescence include which of the following?

A. Dependence vs. peer group.
B. Family vs. privacy.
C. Idealization vs. intellectualized control.
D. Identity, role, and character.
E. Identity vs. inferiority.

The correct response is option D (p. 93; see Table 2–5). The eight developmental themes of adolescence are

- Dependence vs. independence
- License vs. intellectualized control
- Family vs. peer group
- Normalization vs. privacy
- Idealization vs. devaluation
- Identity, role, and character
- Sexuality: identity, role, and partner; masturbation/mutual pleasure
- Reshuffling of defenses (style)

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CHAPTER 3

Theories of the Mind and Psychopathology

Select the single best response for each question.

3.1 A husband and wife frequently engage in unproductive arguments. Even when the couple converses without arguing, the husband reveals little about his past relationships, and what he does divulge comes out a bit disorganized. Particularly frustrating to the wife is the husband's practice, during the couple's arguments, of talking in a nonlinear, general fashion, accusing her of doing everything "wrong," just like his mother. According to the topographical model of the mind, which of the following is true about the husband in this example?

A. His system position is probably consistent with primary process.
B. His system position is probably consistent with secondary process.
C. His dynamic position is probably not repressed.
D. His system position is probably word-oriented and declarative.
E. He is probably motivated by the reality principle.

The correct response is option A (p. 111; see Table 3–1). In primary process, time flows equally in both directions, permitting the blending of past, present, and future; an idea and its opposite may coexist, and mental contents are condensed and displaced freely. Also, as noted in Table 3–1, primary process is image oriented, connotative, nonlinear, not time bound, and symbolic.

3.2 A husband is plagued by feelings of incompetence. When he comes home, he scans the house for any sign that it is his wife and not himself who is incompetent. He attacks her on flimsy pretexts, assuming the role of self-righteously competent spouse saddled with an incompetent wife. Not only does the wife feel attacked and upset, she also believes that she is incompetent, even though others disagree with her self-assessment. The psychological defense or process illustrated in this example is

A. Denial.
B. Projection.
C. Projective identification.
D. Reversal.
E. Undoing.

The correct response is option C (p. 123). The husband has projected an entire piece of his identity onto his wife. When projective identification occurs in an intimate or empathic relationship, the recipient of the projection feels altered by it. In this example, the wife not only may feel attacked but also may actually take on the identity of incompetence projected onto her.

3.3 To facilitate transference, the psychotherapist should

A. Ask a lot of questions to show interest.
B. Avoid talking unless asked a question.
C. Discuss a personal opinion to facilitate disclosure by the patient.
D. Wait for most details, because the manner in which the patient reports material is also a clue.

E. Not be too aggressive with questions about suicidal ideation, because the material will come out as necessary over time.

The correct response is option D (p. 125). By not discussing reality, personal opinions, private reflections, or details of personal biography, the analyst leaves the field open for the patient to supply the missing details, and the transference emerges like a projective test. The style with which the patient reports material to the analyst, therefore, becomes a clue about how the unconscious processes of that patient work.

3.4 *Hunger* is an example of a patient's drive to bond with another person, according to which theory of the mind?

A. Self psychology.
B. Object relations.
C. Classical structural.
D. Topographical.
E. Psychosexual.

The correct response is option B (p. 127). Fairbairn was the first true object-relations theorist insofar as he postulated that the primary drive was object seeking. Whereas Freud thought that the drive was primary and the objects interchangeable, Fairbairn thought that the objects were primary and the drives interchangeable. If, for Freud, anyone could satisfy the baby's hunger, for Fairbairn, we were given hunger so that we could have a reason to form a human bond.

3.5 A 44-year-old woman in outpatient psychodynamic psychotherapy is discussing a dream she had the night before. The psychotherapist engages the patient in a discussion about the dream's mystical and cross-cultural aspects, in accordance with a leading theory which postulates that a common set of ideas, symbols, and images are shared by all humankind. This psychotherapy is likely based on the work of

A. Adler.
B. Horney.
C. Jung.
D. Rank.
E. Sullivan.

The correct response is option C (p. 142; see Table 3–8). Jungian technique emphasizes the decoding of archetypal elements in dreams. His technique includes more therapist self-disclosure than does psychoanalysis. The mystical, spiritual, symbolic, and cultural are embraced more than in any other school.

CHAPTER 4

The Psychiatric Interview, Psychiatric History, and Mental Status Examination

Select the single best response for each question.

4.1 Regarding the physical layout of an interview room, the psychiatrist should attend to all of the following *except*

- A. Chairs for patient and physician should be of equal height.
- B. There should be a desk between patient and physician for appropriate therapeutic distance.
- C. A playroom is advised for interactions with children.
- D. In the emergency room, the physician should have quick access to the door.
- E. Extraneous noise should be minimized or avoided.

The correct response is option B (pp. 159–160). The psychiatrist does everything possible to put the patient at ease during the interview. The setting should be one that promotes comfort for both patient and psychiatrist. Chairs should be approximately equal in height so that neither party is looking down on the other. There should be no barriers, such as a desk, between the patient and the physician, and there should be sufficient light to maximize the psychiatrist's visual observation without glaring light that would disturb the patient. Background sounds should be minimized. Distractions such as bubbling fish tanks, which psychiatrists may like for aesthetic reasons, should not mar the quiet of an interview room, because they may interfere with the patient's concentration. For young children, a playroom setup, with toys that children can express themselves with, is preferable for diagnostic interviewing.

In hospital emergency department settings, a quiet room should be available with a mattress and no removable (and potentially dangerous) objects. Such a room will prove to be the safest setting in which to interview a psychotic patient who has exhibited out-of-control behaviors. In addition to privacy and comfort, safety is an important consideration. With a potentially agitated paranoid patient, it is important for the psychiatrist to have unimpeded access to an exit door.

4.2 Regarding physician contacts with the patient's relatives or friends, the physician should generally

- A. Talk to family and friends first for collateral history.
- B. Agree to withhold from the patient information gained from collateral sources.
- C. Suspend the usual practice of physician–patient confidentiality when imminent dangerousness is present.
- D. Withhold from the patient information learned from collateral sources.
- E. Disclose the content of the interview to concerned family members, even in the absence of an emergency.

The correct response is option C (p. 161). An exception to this rule (of not talking to relatives or third parties) occurs when the psychiatrist judges the patient to be in imminent danger of hurting him- or herself or others and when the patient refuses voluntary hospitalization. In such an instance, the patient must be told why the psychiatrist is obliged to talk to a third party without the patient's permission.

4.3 The behavior of a patient who remains silent during an interview illustrates which type of resistance?

A. Conscious.
B. Ego.
C. Id.
D. Superego.
E. Countertransference.

The correct response is option A (p. 165). One form of conscious resistance by patients is silence. The psychiatrist must acknowledge the difficulties the patient is experiencing and encourage the patient to verbalize material that is difficult to express.

4.4 After listening to several examples of similar behavior in the patient's life story, the psychiatrist offers the observation "When you can't perform up to your own high standards, you appear to act to try to please someone else." This response by the psychiatrist is an example of

A. Reflection.
B. Interpretation.
C. Transition.
D. Self-disclosure.
E. Facilitation.

The correct response is option B (pp. 166–167; see Table 4–6). In *interpretation*, the psychiatrist draws inferences regarding repeated patterns of behaviors he or she observes in the patient.

4.5 After fully exploring the patient's personal history, the psychiatrist proceeds to the next history item by asking, "Is there a family history of psychiatric illness, for example, suicidal behavior, mental retardation, or anxiety, mood, psychotic, substance abuse, or personality disorder?" This would be an example of

A. Excessive direct questions.
B. Preemptive topic shift.
C. Run-on questioning.
D. Put-down.
E. Checklist questioning.

The correct response is option C (p. 169; see Table 4–7). By lumping several questions into a single sentence, the psychiatrist overwhelms the patient and demonstrates a lack of regard for the importance of the patient's answers to the individual questions.

4.6 When interviewing a depressed or suicidal patient, the psychiatrist is advised to do all of the following *except*

A. Begin with assessment of physical appearance and motor behavior.
B. Thoroughly explore neurovegetative signs or symptoms and their effect on patient function.
C. Be attentive to recent psychosocial stressors (especially losses) and recent anniversaries of significant past losses.
D. Allow the patient to set the pace of the interview, avoid excessive engagement, and tolerate long silences.
E. Assess both suicidal cognitions and the patient's ability to control self-destructive impulses.

The correct response is option D (pp. 172–173). The psychiatrist takes an active role when interviewing the depressed patient. The patient is encouraged to verbalize what he or she is experiencing. The psychiatrist empathizes with the patient's pain and mental anguish. Prolonged silences on the part of the psychiatrist are rarely helpful with these patients and should be discouraged.

4.7 On mental status examination, the patient's stream of thought reveals a lack of goal directedness, excessive details, and difficulty with closure. This thought pattern is called

A. Circumstantiality.
B. Tangentiality.
C. Thought blocking.
D. Perseveration.
E. Neologism.

The correct response is option A (p. 181). *Circumstantiality* is a disorder of associations in which the patient exhibits lack of goal directedness, incorporates tedious and unnecessary details, and has difficulty in arriving at an end point.

4.8 Delusions that cannot be understood by other psychological processes are referred to as *primary delusions*. Which of the following is an example of this type of delusion?

A. Poverty.
B. Nihilism.
C. Thought insertion.
D. Persecution.
E. Guilt.

The correct response is option C (p. 182). Examples of primary delusions include thought insertion, thought broadcasting, and beliefs about world destruction.

4.9 Which of the following is *not* considered a perceptual disturbance?

A. Derealization.
B. Illusion.
C. Depersonalization.
D. Delusion.
E. Hallucination.

The correct response is option D (p. 184; see Table 4–10). Perceptual disturbances encompass hallucinations, illusions, depersonalization, and derealization.

CHAPTER 5

Psychological and Neuropsychological Assessment

Select the single best response for each question.

5.1 Psychometric testing instruments notable for their value in assessment of a wide variety of symptom patterns include all of the following *except*

A. Minnesota Multiphasic Personality Inventory–2 (MMPI-2).
B. Symptom Checklist–90—Revised (SCL-90-R).
C. Brief Psychiatric Rating Scale (BPRS).
D. Hamilton Rating Scale for Depression (HRSD).
E. Millon Clinical Multiaxial Inventory—III (MCMI-III).

The correct response is option D (p. 195; see Table 5–5). The Minnesota Multiphasic Personality Inventory—2, Symptom Checklist–90—Revised, Brief Psychiatric Rating Scale, Personality Assessment Inventory (PAI), and Millon Clinical Multiaxial Inventory—III are "omnibus" measures developed for the assessment of a wide range of symptoms.

5.2 Clinical scales on the Minnesota Multiphasic Personality Inventory–2 include all of the following *except*

A. Hypochondriasis.
B. Hysteria.
C. Lie.
D. Psychopathic deviance.
E. Psychasthenia.

The correct response is option C (p. 196; see Table 5–6). The MMPI-2 includes 10 clinical scales: 1) Hypochondriasis, 2) Depression, 3) Hysteria, 4) Psychopathic Deviate, 5) Masculinity–Femininity, 6) Paranoia, 7) Psychasthenia, 8) Schizophrenia, 9) Hypomania, and 10) Social Introversion.

5.3 Regarding the Hamilton Rating Scale for Depression (HRSD), all of the following are true *except*

A. It contains 17–24 items.
B. It has 3- to 5-point severity scales for each item.
C. It is weighted toward the neurovegetative rather the cognitive symptoms of depression.
D. It is often used in conjunction with the Beck Depression Inventory (BDI).
E. It is self-administered.

The correct response is option E (pp. 198–199; see Table 5–7). The Hamilton Rating Scale for Depression is a clinical interview with 17–24 items using 3- to 5-point severity scales. This instrument allows the clinician to rate the severity of depressive symptoms during an interview with the patient. The Beck Depression Inventory is often used in conjunction with the HRSD. In contrast to the BDI, the HRSD is more systematic in assessing neurovegetative signs.

5.4 Regarding the Wisconsin Card Sorting Test (WCST), all of the following are true *except*

A. It is a test of conceptualization.
B. It requires the subject to match cards on the dimensions of color, number, or form.

C. It requires the subject to derive "rules" based on interpretations of patterned visual stimuli.
D. The examiner changes the "rule" after 10 correct sorts.
E. The examiner prompts the subject that the rule change is imminent.

The correct response is option E (p. 206). The Wisconsin Card Sorting Test requires the patient to induce a concept or rule of organization from patterned visual stimuli. The "rule" of sorting that the examiner reinforces in color, form, or number is changed after the patient correctly sorts 10 cards in a row (indicating that he or she has grasped the rule). The examiner notes the number of concepts correctly induced and the number of perseverative errors in matching.

5.5 Screening instruments that may be administered rapidly for prompt and efficient assessment of personality in a managed care system include all of the following *except*

A. International Personality Disorder Examination Screen (IPDE-S).
B. Iowa Personality Disorder Screen.
C. Self-directedness subscale from the Temperament and Character Inventory.
D. Screen for personality disorders developed from the Inventory of Interpersonal Problems.
E. Minnesota Multiphasic Personality Inventory–2 (MMPI-2).

The correct response is option E (p. 207). In this era of searching for efficient care, some consideration should be given to the use of screening instruments that can be administered rapidly to assess for the potential for personality disorders, disorders that retard and complicate the treatment of Axis I disorders. Four screening instruments deserve consideration: the International Personality Disorder Examination Screen, the Iowa Personality Disorder Screen, the self-directedness subscale from the Temperament and Character Inventory, and a screen for personality disorders developed from the Inventory of Interpersonal Problems.

5.6 Instruments used for the assessment of psychodynamics and patient enabling factors include all of the following *except*

A. Rorschach.
B. Thematic Apperception Test (TAT).
C. Minnesota Multiphasic Personality Inventory–2 (MMPI-2).
D. Social Adjustment Scale—Self-Report (SAS-SR).
E. Millon Clinical Multiaxial Inventory—III (MCMI-III).

The correct response is option D (p. 211; see Table 5–10). The standard battery of instruments developed for the assessment of factors relevant to psychodynamic and psychoanalytic theory and treatment approaches includes the Rorschach, the Thematic Apperception Test, the Minnesota Multiphasic Personality Inventory–2, the Symptom Checklist–90—Revised, and the Millon Clinical Multiaxial Inventory—III.

CHAPTER 6

Laboratory and Other Diagnostic Tests in Psychiatry

Select the single best response for each question.

6.1 A supplemental laboratory/diagnostic test recommended for evaluating physical conditions in nondemented, mood-disordered patients is

A. Chest X ray.
B. Electrocardiogram.
C. Complete blood count.
D. Magnetic resonance imaging scan.
E. Serum vitamin B_{12} and folate levels.

The correct response is option D (p. 223; see Table 6–3). Magnetic resonance imaging scanning is performed as a supplemental test; the other four procedures are considered more routine screening tests.

6.2 A single, 53-year-old man is found lying on the floor in his apartment, having apparently lost consciousness. In the emergency room, he is alert, appears oriented, and reports no complaints; however, he has a large bruise on the left side of his head above the ear. He is admitted overnight for observation and in the morning is noted to be lethargic and disoriented, despite having taken no medications. Which of the following tests would be contraindicated?

A. Carotid ultrasound.
B. Computed tomography.
C. Electroencephalogram.
D. Lumbar puncture.
E. Magnetic resonance imaging.

The correct response is option D (p. 224). Some possible contraindications to a lumbar puncture include situations involving raised intracranial pressure, the presence of an intracranial mass lesion (e.g., brain tumor, brain abscess, subdural hematoma, intracerebral hemorrhage), skin infection around the lumbar puncture site, and the patient's use of anticoagulants.

6.3 An advantage of magnetic resonance imaging (MRI) over computed tomography (CT) is that MRI

A. Provides better detection of calcified brain lesions.
B. Is less anxiety provoking.
C. Is less expensive.
D. Provides better visualization of lesions in the brain stem.
E. Requires a shorter period of patient cooperation.

The correct response is option D (p. 229). MRI provides better visualization of lesions in the posterior fossa, brain stem, temporal, and apical brain areas (i.e., areas closely surrounded by skull bone).

6.4 Prior to starting a patient on lithium carbonate, the psychiatrist should order which of the following tests?

A. Reticulocyte count.
B. Platelet count.
C. Erythrocyte sedimentation rate.
D. Liver function tests.
E. Thyroid function tests.

The correct response is option E (p. 232; see Table 6–8). The following laboratory evaluations are recommended before treatment with lithium:

- Complete blood count
- Serum electrolytes
- Blood urea nitrogen
- Serum creatinine
- Thyroid function tests
- Urinalysis
- Electrocardiogram
- Pregnancy test (in potentially childbearing patients)

6.5 Research advantages of functional magnetic resonance imaging (fMRI) over positron emission tomography (PET), single photon emission computed tomography (SPECT), and regional cortical blood flow (rCBF) studies include all of the following *except*

A. fMRI offers superior spatial/temporal resolution.
B. fMRI avoids exposure to ionizing radiation.
C. fMRI does not need a source of radiopharmaceuticals.
D. fMRI does not have the same degree of limitations on multiple studies.
E. fMRI can be used by patients with pacemakers.

The correct response is option E (p. 245; see Table 6–11). fMRI has the following advantages over SPECT, PET, and rCBF:

- fMRI avoids exposure to ionizing radiation.
- fMRI is increasingly available and does not need a source of radiopharmaceuticals as do SPECT, PET, and rCBF.
- fMRI offers superior spatial/temporal resolution compared with SPECT, PET, and rCBF.
- fMRI does not have the same degree of limitations on multiple studies that SPECT, PET, and rCBF have.

CHAPTER 7

Delirium, Dementia, and Amnestic Disorders

Select the single best response for each question.

7.1 Compared with the hypoactive subtype of delirium, the hyperactive subtype is characterized by all of the following *except*

A. Restlessness.
B. Irritability.
C. Rapid speech.
D. Hypervigilance.
E. More severe cognitive impairment.

The correct response is option E (p. 260). Liptzin and Levkoff (1992) characterized delirious patients with restlessness, hypervigilance, rapid speech, irritability, and combativeness as hyperactive, whereas those showing slowed speech and kinetics, apathy, and reduced alertness were designated hypoactive. Hypoactive patients tend to have more severe cognitive disturbances and a poorer prognosis.

7.2 The neurotransmitters most widely accepted to be dysregulated in delirium are

A. Norepinephrine and acetylcholine.
B. Norepinephrine and serotonin.
C. Serotonin and acetylcholine.
D. Acetylcholine and dopamine.
E. Dopamine and serotonin.

The correct response is option D (p. 263). Regarding specific changes in neurotransmitters in delirium, the two most accepted are a reduction in acetylcholine activity and an excess of dopamine activity.

7.3 Clinical factors favoring the use of central nervous system neuroimaging to evaluate cases of delirium include all of the following *except*

A. Head injury.
B. Anticholinergic exposure.
C. History of cancer.
D. High suspicion for cerebrovascular accident (CVA).
E. History of HIV disease.

The correct response is option B (p. 265). Neuroimaging should be considered for patients with head injuries, focal findings, cancer, stroke risk, AIDS, and atypical presentations (e.g., young, healthy, lack of identifiable precipitants).

7.4 Risk factors for prolonged QTc with intravenous haloperidol include all of the following *except*

A. Bradycardia.
B. Hypomagnesemia.
C. Congenital long-QT syndrome.
D. Preexisting cardiac disease.
E. Hyperkalemia.

The correct response is option E (p. 272). In severe delirium refractory to boluses, continuous haloperidol infusions of 3–25 mg/hour have been used safely. Awareness and management of risk factors for prolonged QTc (hypokalemia, hypomagnesemia, bradycardia, congenital long-QT syndrome, preexisting cardiac disease, and drug–drug interactions) are advised. Therefore, even though the association between haloperidol use and torsades des pointes is unclear, QTc intervals beyond 450 msec or 25% over baseline should prompt a cardiology consultation, a dosage reduction, or discontinuation of the antipsychotic agent.

7.5 Which of the following is classified as a subcortical dementia?

A. Dementia of the Alzheimer's type.
B. Dementia due to Pick's disease.
C. Dementia due to Parkinson's disease.
D. Vascular dementia (poststroke).
E. Dementia due to Creutzfeldt-Jakob disease.

The correct response is option C (p. 275; see Table 7–7). Subcortical dementias include those associated with HIV, Parkinson's disease, Huntington's disease, and multiple sclerosis.

7.6 Established and proposed risk factors for Alzheimer's disease include all of the following *except*

A. Trisomy 21.
B. Increased age.
C. Female gender.
D. History of closed head injury.
E. Presence of the apolipoprotein E (APOE) ε3 allele on chromosome 19.

The correct response is option E (p. 276; see Table 7–8). Established and proposed risk factors for dementia of the Alzheimer's type are as follows:

- Increased age
- Female gender
- Head trauma
- Small head size
- Family history
- Low childhood intelligence
- Limited education
- Childhood rural residence
- Large sibships
- Smoking
- Never having married
- Depression
- Diabetes mellitus
- Increased total cholesterol
- Increased platelet membrane fluidity
- Apolipoprotein E (APOE) ε4 allele on chromosome 19
- Abnormalities on chromosomes 1, 6, 12, 14, and 21
- Trisomy 21

7.7 Frontotemporal dementia is characterized by all of the following *except*

A. Earlier age at onset than Alzheimer's disease.
B. Deficits in executive functions.
C. Personality changes.
D. Attentional deficits.
E. Early anterograde and retrograde amnesia.

The correct response is option E (p. 280). Frontotemporal dementia features an earlier age at onset, executive dysfunction, attentional deficits, and personality changes with relatively spared memory and visuospatial functions.

7.8 In a patient with suspected dementia of the Alzheimer's type, which of the following is a sensitive early marker of decreased cognitive function that is detectable by neuroimaging?

A. Ventriculomegaly.
B. White matter disease.
C. Hippocampal atrophy.
D. Sulcal widening.
E. Diffuse cortical atrophy.

The correct response is option C (p. 286 and Figure 7–8). In cases of suspected dementia of the Alzheimer's type, hippocampal atrophy may serve as a sensitive early marker of cognitive decline.

7.9 All of the following cholinesterase inhibitors have been approved by the U.S. Food and Drug Administration (FDA) for the treatment of dementia of the Alzheimer's type *except*

A. Tacrine.
B. Donepezil.
C. Galantamine.
D. Rivastigmine.
E. Metrifonate.

The correct response is option E (p. 289). Tacrine, donepezil, rivastigmine, and galantamine are FDA-approved for dementia of the Alzheimer's type; metrifonate, eptastigmine, and controlled-release physostigmine are under investigation.

7.10 Regarding transient global amnesia, which of the following is true?

A. A typical episode lasts 24 hours.
B. Level of consciousness is decreased.
C. Orientation to self is nearly always affected.
D. Baseline cognitive function is spontaneously recovered.
E. It is more common in women.

The correct response is option D (p. 295). Transient global amnesia is a form of amnestic disorder characterized by an abrupt episode of profound anterograde amnesia and a variable inability to recall events that occur during the episode. Episodes typically last for only a few minutes or hours, ending with a rapid, spontaneous restoration of intact cognitive function. Mean duration of the amnestic period is 4.2 hours; periods greater than 12 hours are exceptional. The patient's level of consciousness and orientation to self are unaffected during the episode. Patients are often bewildered and confused during an episode and may ask repeated questions about their circumstances. No data are available to suggest that transient global amnesia is associated with focal neurological features or with any comorbid psychiatric illness. Transient global amnesia is more common in men and usually occurs after age 50 years.

Reference

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CHAPTER **8**

Substance Use Disorders

Select the single best response for each question.

8.1 Which of the following is *incorrect* regarding DSM-IV-TR (American Psychiatric Association 2000) criteria for substance dependence?

A. Tolerance and withdrawal symptoms are required for a diagnosis of substance dependence.
B. Tolerance and withdrawal symptoms are by themselves insufficient for a diagnosis of substance dependence.
C. Substance dependence course specifiers include remission (partial or full), on agonist therapy, and in a controlled environment.
D. Three or more symptoms of substance dependence must be present for 12 months or more to qualify for a dependence diagnosis.
E. Substance abuse criteria do not include tolerance, withdrawal, and compulsive use.

The correct response is option A (p. 315; Table 8–1). Dependence is a pattern of repeated self-administration that can result in tolerance, withdrawal, and compulsive drug-taking behavior. According to DSM-IV-TR criteria for substance dependence (see table), a patient must exhibit at least 3 behaviors from a 7-item polythetic criteria set over a 12-month period.

DSM-IV-TR criteria for substance dependence

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

(1) tolerance, as defined by either of the following:
  (a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect
  (b) markedly diminished effect with continued use of the same amount of the substance
(2) withdrawal, as manifested by either of the following:
  (a) the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for withdrawal from the specific substances)
  (b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
(3) the substance is often taken in larger amounts or over a longer period than was intended
(4) there is a persistent desire or unsuccessful efforts to cut down or control substance use
(5) a great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects
(6) important social, occupational, or recreational activities are given up or reduced because of substance use
(7) the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)

Specify if:
  With Physiological Dependence: evidence of tolerance or withdrawal (i.e., either Item 1 or 2 is present)
  Without Physiological Dependence: no evidence of tolerance or withdrawal (i.e., neither Item 1 nor 2 is present)

8.2 Alcohol withdrawal symptoms include all of the following *except*

A. Coarse (5–7 Hz) tremor of hands, tongue, or eyelids.
B. Nausea and/or vomiting.
C. Increased autonomic nervous system activity.
D. Transient hallucinations.
E. Hypersomnia.

The correct response is option E (p. 317). Features of alcohol withdrawal include coarse tremor of the hands, tongue, or eyelids; nausea or vomiting; malaise or weakness; autonomic hyperactivity; orthostatic hypotension; anxiety, depressed mood, or irritability; transient hallucinations (generally poorly formed) or illusions; headache; and insomnia. The generalized tremor, which is coarse and of intermediate frequency (5–7 Hz), can worsen with motor activity or emotional stress; it is most likely to be observed on extension of the hands or tongue. Often patients complain only of feeling shaky inside.

8.3 Regarding alcohol withdrawal delirium or delirium tremens, which of the following is true?

A. Symptoms may include abnormal perceptions, agitation, terror, insomnia, and fever.
B. Presentation tends to be stereotypical.
C. Symptom onset is usually 5–6 days after cessation of alcohol consumption, with peak of symptoms at 7–8 days.
D. Fatality rate in contemporary practice is 25%.
E. It is often seen in patients with less than 5 years of heavy drinking.

The correct response is option A (p. 317). Delirium tremens (DTs) can result from alcohol withdrawal or intoxication. It is a condition that differs from uncomplicated withdrawal in that it is a delirium that may include abnormal perceptions, agitation, terror, insomnia, mild fever, or autonomic instability. A wide variation of presentations can occur, from quiet confusion, agitation, and peculiar behavior lasting several weeks to marked abnormal behavior, vivid terrifying delusions, and other disorders of perception. Hallucinations may be auditory and of a persecutory nature, or they may be kinesthetic, such as tactile sensations of crawling insects. DTs can appear suddenly, but it usually occurs gradually 2 to 3 days after cessation of drinking, with peak intensity on day 4 or 5. It is usually benign and short-lived: the majority of cases subside after 3 days; subacute symptoms may last 4 to 5 weeks. Although early reports stated that up to 20% of cases may end fatally, later reports have found that the fatality rate may be less than 1%. DTs generally occurs in withdrawing alcoholic patients with 5 to 15 years of heavy drinking.

8.4 Regarding comorbid alcohol dependence and depression, “primary” major depression is more likely in

A. Males.
B. Caucasians.
C. Unmarried patients.
D. Patients without a history of suicide attempts.
E. Patients without a family history of mood disorder.

The correct response is option B (p. 328). According to a study conducted in a large population of alcoholic patients (Schuckit et al. 1997), primary major depressive episodes were more likely to occur in patients who were female, white, and married; who had had experience with fewer drugs and had received less treatment for alcoholism; who had attempted suicide; and who had a close relative with a major mood disorder.

8.5 Regarding persons with type I and type II alcoholism (according to Cloninger),

A. Persons with type I alcoholism have onset before age 25 years.
B. In persons with type I alcoholism, drinking is unaffected by circumstances.
C. Persons with type I alcoholism are generally unable to maintain abstinence.
D. Persons with type II alcoholism will seek alcohol spontaneously, regardless of external circumstances.
E. Persons with type II alcoholism are rarely involved in fights and arrests.

The correct response is option D (p. 329). In persons with type I alcoholism (Cloninger et al. 1988), heavy drinking generally starts after age 25 years and is reinforced by external circumstances. These individuals have greater ability to abstain for long periods of time and frequently feel loss of control, guilt, and fear about their alcohol dependency. In contrast, persons with type II alcoholism generally have an early onset—before age 25 years—and show spontaneous alcohol-seeking behavior regardless of external circumstances. Fights and arrests are common with these individuals, and they rarely experience feelings of loss of control, guilt, or fear about their alcohol dependency.

8.6 Clinical laboratory findings typical of alcohol abuse include

A. Decreased uric acid.
B. Decreased lactate dehydrogenase (LDH).
C. Decreased gamma-glutamyl transpeptidase (SGGT).
D. Elevated carbohydrate-deficient transferrin (CDT).
E. Increased albumin, B_{12}, and folic acid.

The correct response is option D (p. 335; see Table 8–8). Laboratory findings associated with alcohol abuse include the following:

- Blood alcohol level
- Positive Breathalyzer test
- Elevated mean corpuscular volume
- Elevated serum glutamic-oxaloacetic transaminase (SGOT), serum glutamic-pyruvic transaminase (SGPT), LDH
- Elevated SGGT (particularly sensitive)
- Elevated CDT
- Decreased albumin, B_{12}, folic acid (due to malnutrition)
- Increased uric acid, elevated amylase, and evidence of bone marrow suppression

8.7 Regarding medication interactions with alcohol, all of the medications listed produce the signs and symptoms shown *except*

A. Disulfiram—flushing, diaphoresis, vomiting, confusion.
B. Oral anticoagulants—increased effect with acute intoxication, decreased effect with chronic use.
C. Phenytoin—increased anticonvulsant effect with acute intoxication.
D. Salicylates—gastrointestinal bleeding.
E. Antihistamines—decreased central nervous system depression.

The correct response is option E (p. 362; see Table 8–22). Medication interactions with alcohol can produce the following adverse effects:

- Disulfiram—flushing, diaphoresis, vomiting, confusion
- Oral anticoagulants—increased effect with acute intoxication, decreased effect after chronic use
- Antimicrobials—minor disulfiram reaction
- Sedatives, hypnotics, narcotics, antihistamines—increased central nervous system depression
- Diazepam—increased absorption
- Phenytoin—increased anticonvulsant effect with acute intoxication; alcohol intoxication or withdrawal may lower seizure threshold after chronic alcohol abuse
- Salicylates—gastrointestinal bleeding
- Chlorpromazine—increased levels of alcohol, lowered seizure threshold
- Monoamine oxidase inhibitors—adverse reactions to tyramine in some alcoholic beverages

8.8 Characteristics of persons with familial alcoholism include all of the following *except*

A. Early onset.
B. More severe social consequences of drinking.
C. Poor academic performance.
D. Decreased risk of antisocial behavior.
E. Poor prognosis with treatment.

The correct response is option D (p. 365; see Table 8–23). Persons with familial alcoholism have been found to have an earlier onset of problem drinking, more severe social consequences, a less consistently stable family involvement, poorer academic and social performance in school, more antisocial behavior, and a poorer prognosis in treatment.

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CHAPTER 9

Schizophrenia and Other Psychotic Disorders

Select the single best response for each question.

9.1 A 45-year-old woman has for 4 months had the belief that neighbors are plotting to harm her, although no overt comments have been heard. She perceives them as hostile in the way they look at her. Others have not noticed anything significant and have tried to reassure her, but she insists that something is going on and becomes markedly upset when confronted. She denies auditory hallucinations. She is able to care for her two children at home. Psychiatric and medical history are otherwise unremarkable. Most likely, this patient is suffering from

A. No disorder.
B. Delusional disorder.
C. Schizoaffective disorder.
D. Schizophreniform disorder.
E. Schizophrenia.

The correct response is option B (pp. 382–384). Unlike delusional disorder, schizophrenia is characterized by two or more of the following: delusions, hallucinations, disorganized speech, grossly disorganized behavior, and negative symptoms. This patient exhibits delusions in the absence of other symptoms necessary for a diagnosis of schizophrenia or schizophreniform disorder.

9.2 Approximately what percentage of patients with schizophrenia show impairment on neuropsychological assessment?

A. 0%–20%.
B. 20%–40%.
C. 40%–60%.
D. 60%–80%.
E. 80%–100%.

The correct response is option C (p. 393). Neuropsychological impairment is not restricted to a small subset of patients; measurable impairment is present in 40%–60% of patients with schizophrenia.

9.3 Which subtype of schizophrenia is characterized by echolalia/echopraxia, peculiarities of voluntary movement, and catalepsy?

A. Disorganized.
B. Catatonic.
C. Paranoid.
D. Residual.
E. Undifferentiated.

The correct response is option B (p. 395; see Table 9–8). In the disorganized subtype of schizophrenia, silly and childlike behavior is common. This subtype is associated with extreme social impairment, poor premorbid functioning, and poor long-term functioning.

9.4 Which of the following features is associated with a positive outcome for patients with schizophrenia?

A. Younger age at onset.
B. Male gender.
C. Never having been married.
D. Living in an industrialized nation.
E. Having affective symptoms.

The correct response is option E (p. 400; Table 9–10). Prediction of outcome remains a difficult task because of the changing definitions and diagnostic criteria employed. See table, "Features associated with good and poor outcome," for a summary of commonly reported diagnostic factors in schizophrenia.

Features associated with good and poor outcome in schizophrenia

Feature	Good outcome	Poor outcome
Age	Older	Younger
Gender	Female	Male
Marital history	Married	Never married
Transcultural factors	Developing nations	Industrialized nations
Affective symptoms	Present	Absent

9.5 According to epidemiological studies of first-episode psychosis around the world, the average time interval between onset of psychotic symptoms and initiation of treatment is

A. Less than 1 year.
B. 1–2 years.
C. 3–4 years.
D. 5–6 years.
E. 7–8 years.

The correct response is option B (p. 402). Studies have consistently shown that there is a time lag averaging 1–2 years between onset of psychotic symptoms and initiation of treatment.

9.6 The most consistent finding in structural imaging studies of schizophrenia patients is

A. Frontal lobe enlargement.
B. Decrease in frontal lobe size.
C. Increased size of the frontal lobe relative to the cerebellum.
D. Thalamus enlargement.
E. Cerebral ventricular enlargement.

The correct response is option E (p. 405). Cerebral ventricular enlargement is the most consistently replicated finding, but sulcal enlargement or abnormalities in cortical or subcortical subregions are also reported.

9.7 Positron emission tomography (PET) and single photon emission computed tomography (SPECT) research into the origin of hallucinations has yielded which of the following findings in schizophrenia patients experiencing hallucinations?

A. Decreased blood flow to the supplementary motor area.
B. Increased blood flow to the left middle temporal gyrus.
C. Deactivation in the cerebellum.
D. Deactivation in the thalamus.
E. Deactivation in the limbic region.

The correct response is option A (p. 409). In their systematic study of hallucinations, the research group of McGuire et al. (1996) found that schizophrenia patients with hallucinations had decreased cerebral blood flow in the brain areas used to monitor speech, such as the left middle temporal gyrus and supplementary motor area. This research group has also examined cerebral blood flow in schizophrenia patients experiencing auditory hallucinations. Activations were found primarily in subcortical regions (thalamus, striatum), limbic and paralimbic regions (anterior cingulate, parahippocampal gyrus), and cerebellum, leading the investigators to speculate that whereas activity in subcortical regions may generate or moderate hallucinations, hallucination content (e.g., auditory, tactile) may be determined by the specific neocortical regions that are engaged (Silbersweig et al. 1995).

9.8 Although the duration of treatment for relapse prevention has not been established, guidelines from an international consensus conference recommend how many years of medication treatment for patients with schizophreniform disorder after the initial psychotic episode?

A. Less than 1 year.
B. 1–2 years.
C. 3–4 years.
D. 5–6 years.
E. 7–8 years.

The correct response is option B (p. 416). According to these consensus guidelines (Kissling 1991), at least 1–2 years of treatment are recommended after the initial episode because of the high risk of relapse and the possibility of social deterioration from further relapses.

9.9 All of the following properties of the atypical antipsychotics are true *except*

A. They block serotonin 5-HT_{2A} receptors in the frontal cortex.
B. They block serotonin 5-HT_{2A} receptors in the striatum.
C. They are associated with hyperlipidemia.
D. They are associated with glucose intolerance.
E. Their decreased risk of EPS (compared with atypical antipsychotics) is likely due to their slow dissociation from D_2 receptors.

The correct response is option E (p. 414). Not only do the second-generation (i.e., atypical) antipsychotics appear to be more effective than first-generation antipsychotics in reducing positive and negative symptoms, but they may also be superior in improving depression and reducing cognitive dysfunction in schizophrenia.

9.10 Evidence-based medicine reveals that patients with schizophrenia do best in terms of functional ability when treated with which of the following psychotherapies?

A. Cognitive-behavioral.
B. Interpersonal.
C. Supportive.
D. Psychoanalysis.
E. Psychodynamic.

The correct response is option A (p. 419). A growing body of evidence points to the efficacy of cognitive-behavioral therapy in schizophrenia, particularly for amelioration of residual psychotic symptoms.

References

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McGuire PK, Silbersweig DA, Wright I, et al: The neural correlates of inner speech and auditory verbal imagery in schizophrenia: relationship to auditory verbal hallucinations. Br J Psychiatry 169:148–159, 1996

Silbersweig DA, Stern E, Frith C, et al: A functional neuroanatomy of hallucinations in schizophrenia. Nature 378:176–179, 1995

CHAPTER 10

Mood Disorders

Select the single best response for each question.

10.1 In the Epidemiologic Catchment Area study, the risk of attempted suicide in depressed patients was approximately how many times greater than the risk in patients with other disorders?

A. 2.
B. 3.
C. 5.
D. 10.
E. 40.

The correct response is option E (p. 440). The lifetime risk of suicide in mood disorders is 10%–15%. According to the Epidemiologic Catchment Area study, the risk of attempted suicide was increased 41-fold in depressed patients compared with those with other diagnoses (Petronis et al. 1990).

10.2 Compared with unipolar depression, bipolar depression

A. Has a later onset.
B. Has a more gradual onset.
C. Carries a greater risk for suicide.
D. Presents with insomnia rather than hypersomnia.
E. Is less frequently accompanied by psychotic symptoms in younger patients.

The correct response is option C (p. 446; Table 10–7). There are a number of differences between unipolar and bipolar depression that clinicians should keep in mind when considering these diagnoses (see table).

Differences between unipolar and bipolar depression

Unipolar	Bipolar
Later onset	Earlier onset
More gradual onset	Acute onset
Insomnia	Hypersomnia
Lower risk of suicide	Greater risk of suicide
Less frequently accompanied by psychotic symptoms in younger patients	Greater likelihood of psychotic symptoms in younger patients

10.3 Bipolar disorder patients experiencing an episode of depression have all of the following atypical symptoms that unipolar patients would have *except*

A. Hypersomnia.
B. Anergia.
C. Carbohydrate craving.
D. Mood reactivity.
E. Psychomotor slowing.

The correct response is option D (pp. 455–456). Classical bipolar depression is characterized by "atypical" symptoms such as hypersomnia, anergia, carbohydrate craving, and psychomotor slowing. However, in contrast to the case in atypical unipolar depression, mood is usually not reactive in bipolar depression that is not mixed with hypomania.

10.4 Seasonal variations occur in most mood disorders. Which of the following statements is true?

A. In the Northern Hemisphere, unipolar depression is more likely to recur in the fall.
B. In the Northern Hemisphere, bipolar depression is more likely to recur in the spring.

C. Hospitalization rates for a given episode (e.g., depression) of bipolar disorder in the Southern Hemisphere occur at the same time as in the Northern Hemisphere.
D. In the Northern Hemisphere, hospitalizations for mania peak in the winter.
E. The risk of suicide is highest during the spring.

The correct response is option E (p. 460). Examples of seasonal variations in mood disorders include the greater likelihood of unipolar depression recurrence in the spring and of mania recurrence during the summer. Contrary to popular wisdom, the time of greatest risk of suicide is not during the Christmas holidays but during the months of May and June. Hospital admissions for unipolar depression peak in the spring, whereas admissions for mania peak in the summer. The observations that seasonal variations in mood disorders in the Southern Hemisphere are the reverse of those in the Northern Hemisphere (e.g., more admissions for mania during the winter) and that the pattern of seasonal affective disorder (SAD) is the reverse in the Northern and Southern Hemispheres support the hypothesis that these changes are dependent on variations in available daylight.

10.5 The primary reason that biological tests (e.g., dexamethasone suppression test) are not used for the diagnosis of depression is that they

A. Are too costly.
B. Cannot outperform the "gold standard"—clinical interview.
C. Are not available at all hospitals and laboratories.
D. Have too low sensitivity.
E. Have too high specificity.

The correct response is option B (p. 477). Laboratory tests are useful for examining the pathophysiology of mood disorders, but the large numbers of false-positive and false-negative results make such tests relatively ineffective for diagnosing mood disorders. In addition, no laboratory test can outperform the gold-standard clinical interview to which it is referenced, and no studies exist in which diagnosis was prospectively predicted by laboratory test alone.

10.6 A 45-year-old woman presents to the outpatient clinic for evaluation of depression. She reports depressed mood, hopelessness, increased self-criticism, and indecision—the severity is judged to be mild by the clinician. Before the episode of depression began, she had been ruminating about being "a failure" with regard to home and work issues. Which treatment would best help this patient to address her symptoms in general and specifically her feeling that she is "a failure"?

A. Cognitive-behavioral psychotherapy.
B. Group psychotherapy.
C. Interpersonal psychotherapy.
D. Antidepressant medication.
E. Psychodynamic psychotherapy.

The correct response is option A (p. 487). According to the cognitive model, early experience leads to the development of global negative assumptions called schemata. Depressive schemata involve all-or-nothing assumptions such as the following:

- If I'm not completely happy, I'll be totally miserable.
- If something isn't done exactly right, it's worthless.
- If I'm not perfect, I'm a failure.

CBT would address this patient's global negative assumption that she is a failure.

10.7 All of the following are true of the antidepressant mirtazapine *except*

A. It is chemically related to the antidepressant mianserin.
B. It is an antagonist at 5-HT$_2$ receptors.
C. It is an agonist at presynaptic α_2-adrenergic receptors.
D. It is an antagonist at 5-HT$_3$ receptors.
E. Sedation and weight gain are common side effects.

The correct response is option C (p. 494). Mirtazapine is an *antagonist* at presynaptic α_2-adrenergic receptors.

10.8 Which of the following statements is true regarding novel medications for the treatment of depression?

A. Omega-3 fatty acids have been recently approved as a treatment for depression.
B. Medications that facilitate cortisol release may be effective.
C. S-adenosylmethionine levels are increased in the cerebrospinal fluid of depressed patients; thus, drugs that increase this substance may be effective.
D. Preliminary trials with inositol indicate that this agent may worsen depression.
E. Atypical antipsychotics (e.g., olanzapine) in combination with fluoxetine may work better than either atypical antipsychotics alone or fluoxetine alone.

The correct response is option E (pp. 494–495). In an 8-week, double-blind, random-assignment trial in 28 patients with recurrent, nonbipolar, nonpsychotic depression that had been resistant to antidepressants, olanzapine or fluoxetine alone produced significantly less improvement than the combination of the two medications (Shelton et al. 2001).

10.9 Lamotrigine is being evaluated for efficacy in treating depressive, manic, and mixed episodes in bipolar patients, as well as for rapid cycling. Which of the following statements is true?

A. It is efficacious for bipolar depression.
B. It is efficacious for bipolar depression with psychosis.
C. It lacks efficacy for bipolar mania.
D. It lacks efficacy for rapid cycling.
E. It lacks efficacy as an adjunct to other treatments.

The correct response is option A (p. 499). Lamotrigine was found in controlled trials to be useful in bipolar depression (Ghaemi and Gaughan 2000), and a small controlled study suggested its efficacy in mania (Berk 1999).

10.10 In a collaborative study comparing interpersonal psychotherapy (IPT), cognitive therapy, imipramine plus clinical management, and placebo plus clinical management, IPT was found to be

A. Less efficacious than imipramine.
B. Less efficacious than cognitive therapy.
C. As efficacious as placebo.
D. As efficacious as imipramine but worked slower.
E. More efficacious than imipramine.

The correct response is option D (p. 504). In this collaborative study by Elkin et al. (1989), which compared IPT, cognitive therapy, imipramine plus clinical management, and placebo plus clinical management, IPT was found to be equivalent to imipramine and cognitive therapy at the end of 16 weeks, although imipramine was more rapidly effective.

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CHAPTER 11

Anxiety Disorders

Select the single best response for each question.

11.1 In addition to panic attacks and chronic anxiety, agoraphobia patients commonly experience all of the following *except*

A. Demoralization.
B. Secondary depression.
C. Multiple somatic complaints.
D. Alcohol abuse.
E. Stimulant abuse.

The correct response is option E (p. 548). Besides experiencing panic attacks and chronic anxiety, agoraphobic patients frequently exhibit symptoms of demoralization or secondary depression, multiple somatic complaints, and alcohol or sedative drug abuse.

11.2 Regarding the biological model for panic disorder, which of the following is correct?

A. Intravenous propranolol reliably aborts lactate-induced panic attacks.
B. Yohimbine increases anxiety and decreases 3-methoxy-4-hydroxyphenylglycol (MHPG) in panic disorder patients.
C. Changes in MHPG levels following yohimbine challenge are unaffected by selective serotonin reuptake inhibitor (SSRI) treatment.
D. Intravenous lactate can induce a panic attack in panic disorder patients but not in healthy control subjects.
E. Flumazenil induces panic attacks in healthy control subjects.

The correct response is option D (p. 550). Having been replicated on numerous occasions under proper experimental conditions, the finding that 10 mL/kg of 0.5 molar sodium lactate infused over 20 minutes will provoke a panic attack in most patients with panic disorder but not in healthy control subjects is now a well-accepted fact.

11.3 Systemic illnesses to be considered in the differential diagnosis of panic disorder include all of the following *except*

A. Hyperthyroidism.
B. Hypothyroidism.
C. Pheochromocytoma.
D. Mitral valve prolapse.
E. Hypoparathyroidism.

The correct response is option E (p. 556; see Table 11–4). Medical conditions that can mimic panic disorders include the following:

- Hyperthyroidism
- Hypothyroidism
- Hyperparathyroidism
- Mitral valve prolapse
- Cardiac arrhythmias
- Coronary insufficiency
- Pheochromocytoma
- Hypoglycemia
- True vertigo
- Drug withdrawal
- Alcohol withdrawal

11.4 Regarding antidepressants in the treatment of panic disorder, all of the following are true *except*

A. Fluvoxamine at doses up to 150 mg per day has been shown to be effective.
B. Sertraline has been shown to improve panic symptoms and to increase quality of life in panic disorder.

C. All studies reported to date demonstrate paroxetine's effectiveness for panic disorder at doses of 20 mg per day.
D. Citalopram at doses of 20–30 mg per day has been efficacious in panic disorder.
E. Clomipramine is effective for panic disorder but is generally less well tolerated than SSRIs.

The correct response is option C (pp. 560–561). Although only paroxetine and sertraline are approved by the FDA for this indication, there is no particular reason to believe that SSRIs do not all have comparable efficacy in panic disorder.

11.5 Regarding generalized anxiety disorder (GAD), which of the following is true?

A. Comorbidity for major depression and other anxiety disorders is approximately 20%.
B. Increased benzodiazepine receptor density has been found in peripheral blood cells of GAD patients.
C. GAD patients show a sensitivity to intravenous lactate similar to that observed in panic disorder patients.
D. GAD is considered a more chronic condition than panic disorder, with fewer periods of spontaneous remission.
E. GAD is rare in elderly patients.

The correct response is option D (pp. 566–568). GAD appears to be a more chronic condition than panic disorder in that it involves fewer periods of spontaneous remission.

11.6 Regarding treatment of social phobia, all of the following are true *except*

A. Beta-blockers are useful for the performance anxiety subtype.
B. Monoamine oxidase inhibitors (MAOIs) are effective.
C. SSRIs are the first-line treatment.
D. There are no FDA-approved SSRIs for social phobia.
E. Nefazadone and venlafaxine have been shown to be effective in early open trials.

The correct response is option D (pp. 576–577). In recent years, newer antidepressants have been tested and have shown efficacy in treating social phobia; as a result, the SSRIs have become the first-line treatment for the disorder.

11.7 Types of specific phobia include all of the following *except*

A. Natural environment.
B. Blood–injury–injection.
C. Situational (e.g., cars, elevators, bridges).
D. Public speaking.
E. Other (e.g., choking, vomiting).

The correct response is option D (p. 579). In DSM-IV (American Psychiatric Association 1994), for the first time, types of specific phobias were adopted: natural environment (e.g., storms), animal (e.g., insects), blood–injury–injection, situational (e.g., cars, elevators, bridges), and other (e.g., choking, vomiting).

11.8 In obsessive-compulsive disorder (OCD), obsession/compulsion symptom cluster types include all of the following *except*

A. Dirt and contamination.
B. Counting and checking.
C. Obsessions only.
D. Body-image distortions.
E. Hoarding.

The correct response is option D (p. 582). The various presentations of OCD are based on symptom clusters. One group includes patients with obsessions about dirt and contamination, patients whose rituals center on compulsive washing and avoidance of contaminated objects. A second group includes patients who engage in pathological counting and compulsive checking. A third group includes purely obsessional patients with no compulsions. Primary obsessional slowness is evident in another group of patients in whom slowness is the predominant symptom; patients may spend many hours every day washing, dressing, and eating breakfast, and life goes on at an extremely slow speed. Some patients with OCD, called hoarders, are unable to throw anything out for fear they might someday need something they discarded.

11.9 Regarding the onset of OCD symptoms, all of the following are true *except*

A. Cases of OCD followed the 1920s encephalitis epidemics.
B. Abnormal birth events may lead to OCD.
C. OCD may follow closed head injury.
D. OCD uniformly begins during adolescence.
E. New onset of OCD has been reported during pregnancy.

The correct response is option D (p. 583). In most cases, no particular stress or event precipitates the onset of OCD symptoms, and after an insidious onset there is a chronic and often progressive course. However, some patients describe a sudden onset of symptoms. This is particularly true of patients with a neurological basis for their illness. There is evidence of OCD onset associated with the 1920s encephalitis epidemic, abnormal birth events, head injury, and seizures. Of interest are more recent reports of new onset of OCD during pregnancy.

11.10 Regarding posttraumatic stress disorder (PTSD), all of the following are true *except*

A. Dissociative symptoms are prominent in acute stress disorder (ASD).
B. A diagnosis of ASD is required for a later diagnosis of PTSD.
C. Combat exposure is a common PTSD stimulus in men.
D. PTSD is associated with a high rate of comorbid psychiatric illness.
E. Sexual assault is a common PTSD stimulus in women.

The correct response is option B (pp. 597–598). Whereas dissociative symptoms figure prominently in the definition of ASD, such symptoms are not addressed in the PTSD description. However, it has now been well established by a number of studies, including prospective ones, that ASD is a highly reliable predictor of developing PTSD down the road; it may well be that the two should not be defined as discrete disorders. The most common stressors are combat exposure in men and sexual assault in women. A high rate of comorbid disorders is found in PTSD.

Reference

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington, DC, American Psychiatric Publishing, 1994

CHAPTER **12**

Psychological Factors Affecting Medical Conditions

Select the single best response for each question.

12.1 Type C behavior pattern has been described as a coping style or personality trait with regard to cancer. Patients with this behavior pattern may have poor outcomes because they

A. Are not cooperative with treatment.
B. Are not assertive enough.
C. Express negative emotions too much.
D. Suffer more emotional stress than type A patients.
E. Complain about too little pain medication.

The correct response is option B (p. 633). Temoshok et al. (1985) described a type C behavior pattern (in contrast to the type A studied in coronary disease) exemplified in the cooperative, unassertive patient who suppresses negative emotions, particularly anger, and who accepts and complies with external authorities.

12.2 Which psychosocial intervention has demonstrated an improvement in the quality of life for cancer patients independent of its beneficial effect on symptoms of depression and anxiety?

A. Cognitive-behavior psychotherapy.
B. Group psychotherapy.
C. Interpersonal psychotherapy.
D. Psychodynamic psychotherapy.
E. Psychoeducation.

The correct response is option B (p. 634). In contrast to studies lacking convincing support for an etiological relation between psychological factors and cancer, some studies have shown improvement in the quality of life in cancer patients receiving group therapy. Relaxation training and cognitive-behavioral therapy also have reduced anxiety and depression in cancer patients.

12.3 Which of the following is true regarding psychological factors and diabetes mellitus?

A. Psychological factors and diabetes mellitus are causally related.
B. Actual or threatened loss in the family has no significant effect on the timing of onset of diabetes mellitus.
C. Most studies have been done prospectively.
D. Stressful events are correlated with poorer metabolic control.
E. Individuals with Cluster C personality disorders have poorer metabolic control than do those with Cluster B personality disorders.

The correct response is option D (pp. 636–637). Studies in clinical samples have generally found an association between perceived stress and poorer metabolic control (assessed by blood glucose or HbA1c testing), but such studies are typically cross-sectional, limiting any conclusions about causality.

12.4 The single most important modifiable lifestyle risk factor for illness and the greatest single cause of preventable death is

A. Alcohol.
B. Cigarette smoking.
C. Cocaine.
D. High cholesterol.
E. Obesity.

The correct response is option B (p. 641). Cigarette smoking remains the single most important modifiable risk factor for illness and the greatest single cause of preventable premature deaths.

12.5 A key secondary factor in the progression of peptic ulcer disease is

A. Disasters.
B. *Helicobacter pylori.*
C. Nonsteroidal anti-inflammatory drugs.
D. Obesity.
E. "Neurotic" personality traits.

The correct response is option A (p. 645; see Table 12–7). Primary factors affecting the development and progression of peptic ulcer disease include *Helicobacter pylori* and nonsteroidal anti-inflammatory drugs; secondary factors include disasters, occupational or family conflict, psychological distress (anxiety, depression), smoking, alcohol abuse, poor diet, and insomnia.

Reference

Temoshok L, Heller BW, Sageviel RW, et al: The relationship of psychological factors of prognostic indicators in cutaneous malignant melanoma. J Psychosom Res 29:139–153, 1985

CHAPTER 13

Somatoform Disorders

Select the single best response for each question.

13.1 Which of the following somatoform disorders is primarily characterized by cognitive preoccupations rather than physical symptoms?

A. Conversion disorder.
B. Somatization disorder.
C. Undifferentiated somatoform disorder.
D. Hypochondriasis.
E. Pain disorder.

The correct response is option D (p. 662). Because of their emphasis on preoccupations, hypochondriasis and body dysmorphic disorder more closely resemble obsessive-compulsive or even psychotic disorders than they do the symptom-centered somatoform disorders.

13.2 Regarding somatization disorder, all of the following are true *except*

A. It is the best validated of the somatoform disorders.
B. It is the most stable somatoform disorder over time.
C. This diagnosis predicts high levels of utilization of medical services.
D. It appears to be highly heritable.
E. Its validity as a distinct diagnostic construct has not been challenged.

The correct response is option E (p. 664). Somatization disorder has been the most rigorously studied somatoform disorder and is the best validated in terms of diagnostic reliability, stability over time, prediction of medical utilization, and even heritability. Yet its validity as a discrete syndrome has been challenged.

13.3 All of the following complications are common in somatization disorder *except*

A. Unneeded surgery.
B. Medication dependence.
C. Suicide attempts.
D. Marital separation and divorce.
E. Suicide completions.

The correct response is option E (p. 668). According to Goodwin and Guze (1996), the most frequent and important complications of somatization disorder are repeated surgical operations, drug dependence, suicide attempts, and marital separation or divorce. Suicide attempts are common, but completed suicide is not.

13.4 In conversion disorder, any of the following symptoms are valid for a diagnosis *except*

A. Deficits of voluntary motor function.
B. Blindness.
C. Aphonia.
D. Pain.
E. Deafness.

The correct response is option D (p. 673). Specific symptoms mentioned as examples in DSM-IV-TR (American Psychiatric Association 2000) include motor symptoms such as impaired coordination or balance, paralysis or localized weakness, difficulty swallowing or lump in throat (e.g., “globus hystericus”), aphonia, and urinary retention; sensory symptoms, including hallucinations, loss of touch or pain sensation, double vision, blindness, and deafness; and seizures or convulsions with voluntary motor or sensory components.

13.5 Pseudohallucinations as seen in conversion disorder typically feature

A. Hallucinations as one of many psychotic symptoms.
B. Hallucinations involving a single sensory modality.
C. A naive, childish, or fantastic thematic quality to the hallucinations.
D. Hallucinations that are rarely psychologically meaningful to the patient.
E. Hallucinations that are described only reluctantly to the examiner.

The correct response is option C (p. 676). Conversion disorder hallucinations typically occur in the absence of other psychotic symptoms. Insight that the hallucinations are not "real" is generally retained. Conversion hallucinations often involve more than one modality, whereas hallucinations in psychoses generally involve a single sensory modality (especially auditory; secondarily, tactile). They may have a naive, fantastic, or childish content, as in a fairy tale, and are described eagerly as an interesting story.

13.6 Regarding hypochondriasis, all of the following are true *except*

A. The patient can acknowledge that preoccupations are excessive.
B. Preoccupation is often about a benign illness.
C. The primary concern is disease, rather than just symptoms.
D. It may be considered an "obsessive-compulsive spectrum" disorder.
E. SSRI treatment may be a promising intervention.

The correct response is option B (pp. 679–681). The essential feature in hypochondriasis is preoccupation not with symptoms themselves but rather with the fear or idea of having a serious disease, based on the misinterpretation of bodily signs and sensations. Patients with hypochondriasis as a primary disorder, although extremely preoccupied, are generally able to acknowledge the possibility that their concerns are unfounded. More recently, hypochondriasis has been categorized by some as a posited "obsessive-compulsive spectrum disorder," a class that includes (in addition to obsessive-compulsive disorder) body dysmorphic disorder, anorexia nervosa, Tourette's disorder, and certain impulsive disorders (e.g., trichotillomania and pathological gambling; Hollander et al. 1992). Early results of placebo-controlled, double-blind studies are pending, but anecdotal case reports, open-label trials, and review of preliminary data show some promise for the selective serotonin reuptake inhibitors.

13.7 Regarding body dysmorphic disorder (BDD), which of the following is true?

A. BDD accounts for more than 25% of all patients seeking cosmetic surgery.
B. Patients generally present to psychiatrists on their own.
C. The male:female ratio is estimated as 1:5.
D. 75% of patients never marry.
E. Cosmetic surgery has been shown to resolve BDD symptoms.

The correct response is option D (p. 684). About 75% of individuals with BDD will never marry, and among those who do, most will divorce. Although body dysmorphic disorder is seldom seen in psychiatric settings, Andreasen and Bardach (1977) estimated that 2% of the patients seeking corrective surgery have this disorder. Generally, patients with BDD are seen psychiatrically only after referral from plastic surgery, dermatology, and otorhinolaryngology clinics. The male-to-female ratio is about 1:1. Surgery actually has been recommended as a treatment for this disorder, but there is no clear evidence that it is helpful.

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CHAPTER 14

Factitious Disorders and Malingering

Select the single best response for each question.

14.1 All of the following are true regarding Munchausen syndrome *except*

- A. It accounts for 50% of all factitious disorder patients.
- B. The patient presents with varying physical complaints, which are often dramatic and life threatening.
- C. It is characterized by multiple hospitalizations.
- D. The patient often wanders from place to place.
- E. *Pseudologia fantastica*/pathological lying is common.

The correct response is option A (p. 692). Munchausen syndrome, a term coined by Asher (1951), accounts for about 10% of patients with factitious disorders. The eponym remains in wide use and describes a variant of DSM-IV-TR's (American Psychiatric Association 2000) factitious disorder with predominantly physical signs and symptoms. In this special type of factitious disorder, multiple hospitalizations with dramatic and often life-threatening presentations, wandering from hospital to hospital (peregrination), and pathological lying (*pseudologia fantastica*, the telling of dramatic tales that merge truth and falsehood and that the listener initially finds intriguing) are prominent.

14.2 In the non-Munchausen type of factitious disorder, all of the following are true *except*

- A. The patient is usually a young adult female.
- B. The patient reports a dramatic, colorful lifestyle.
- C. Passive and immature behavior are common.
- D. The patient is often trained and/or employed in health care–related occupations.
- E. Single-system physical complaints and findings are common.

The correct response is option B (p. 692). The vast majority of factitious disorder patients are of the non-Munchausen type. These patients are mostly young women with conforming lifestyles and more family support and involvement than Munchausen patients. These patients have been described as passive and immature, and a significant proportion have health-related jobs or training. Most are not wanderers, have single-system complaints, and generate fewer hospitalizations than do Munchausen patients, but the overall severity and morbidity of their illness may be just as great.

14.3 Regarding psychiatric comorbidities of factitious disorder, all of the following are common *except*

- A. Substance use disorders.
- B. Schizophrenia.
- C. Malingering.
- D. Dissociative disorders.
- E. Eating disorders.

The correct response is option B (p. 694). A factor complicating the diagnosis of factitious disorder is the high prevalence of comorbid disorders. Substance use disorders, personality disorders (particularly borderline and antisocial), malingering, dissociative disorders, eating disorders, suicidality, and mood disorders may coexist.

14.4 Symptoms and presentations suggestive of malingering include which of the following?

- A. Consistent reporting of symptoms.
- B. Clinician-observed patient behavior is consistent with symptoms.
- C. Clinical presentation in a medicolegal context is common.
- D. No apparent incentives to malinger are present.
- E. Consistent presentation of symptoms to various examiners and observers.

The correct response is option C (p. 701; Table 14–6). A suggested clinical decision model for the assessment of malingering is presented in table.

Clinical decision model for the assessment of malingering

The evaluee's presentation meets the following criteria:

- A. Understandable motive to malinger.
- B. Marked variability of presentation as observed in at least one of the following:
  - 1. Marked discrepancies in interview and noninterview behavior.
  - 2. Gross inconsistencies in reported psychotic symptoms.
  - 3. Blatant contradictions between reported prior episodes and documented psychiatric history.
- C. Improbable psychiatric symptoms as evidenced by one or more of the following:
  - 1. Reporting elaborate psychotic symptoms that lack common paranoid, grandiose, or religious themes.
  - 2. Sudden emergence of purported psychotic symptoms to explain antisocial behavior.
  - 3. Atypical hallucinations or delusions.
- D. Confirmation of malingered psychosis by either
  - 1. Admission of malingering following confrontation.
  - 2. Presence of strong corroborative information, such as psychometric data or history of malingering.

14.5 Attributes of malingered hallucinations include

- A. Intermittent rather than continuous hallucinations.
- B. Distinct and clearly audible hallucinations.
- C. Paranoid delusions accompanying the hallucinations.
- D. Ability to state strategies to diminish voices.
- E. Visual hallucinations in black and white.

The correct response is option E (p. 701; see Table 14–7). In regard to hallucinations, malingering should be suspected if any combination of the following is present:

- Continuous rather than intermittent hallucinations
- Vague or inaudible hallucinations
- Hallucinations not associated with delusions
- Stilted language reported in hallucinations
- Inability to state strategies to diminish voices
- Self-report that all command hallucinations were obeyed
- Visual hallucinations in black and white

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CHAPTER 15

Dissociative Disorders

Select the single best response for each question.

15.1 Dissociation (in a general sense; not specific to a disorder) and repression have long been compared. Dissociation, as compared with repression, is characterized by

A. A dynamic conflict with motivated forgetting.
B. Amnesia.
C. An organizational structure which is vertical, with layer upon layer of material.
D. (Dissociated) information being stored in disguised and fragmented forms.
E. Amnesia within the context of a dynamic conflict.

The correct response is option B (p. 711; Table 15–2). As indicated in table ("Differences between dissociation and repression"), dissociation is characterized by amnesia, usually as a result of trauma. The goal of dissociation is to keep traumatic memories out of conscious awareness.

Differences between dissociation and repression

	Dissociation	**Repression**
Organizational structure	Horizontal	Vertical
Barriers	Amnesia	Dynamic conflict
Etiology	Trauma	Developmental conflict over unacceptable wishes
Contents	Untransformed: traumatic memories	Disguised, primary process: dreams, slips
Means of access	Hypnosis	Interpretation
Psychotherapy	Access, control, and working through traumatic memories	Interpretation, transference

15.2 The automaticity of behavior that is seen in dissociative patients is consistent with which of the following discoveries about memory?

A. A separation of explicit (episodic) memory from implicit (semantic) memory.
B. Enhanced basal ganglia activity.
C. A disturbance in implicit (semantic) memory.
D. An enhanced reflective component to memory.
E. Enhanced hippocampal formation activity.

The correct response is option A (p. 712). Modern research on memory shows that there are at least two broad categories of memory, variously described as explicit and implicit or episodic and semantic. These two memory systems serve different functions. Explicit (or episodic) memory involves recall of personal experience identified with the self (e.g., "I was at the ball game last week"). Implicit (or semantic) memory involves the execution of routine operations, such as riding a bicycle or typing. Such operations may be carried out with a high degree of proficiency with little conscious awareness of either their current execution or the learning episodes on which the skill is based. Indeed, the distinction between these two types of memory may account for certain dissociative phenomena.

15.3 Which of the following symptoms of dissociation is a predictor of later posttraumatic stress disorder (PTSD)?

A. Automatic movements.
B. Feelings of unreality.
C. Lack of emotion.
D. Numbing.
E. Sense of detachment.

The correct response is option D (p. 713). Researchers have observed that numbing (i.e., loss of responsiveness in the wake of trauma) is a predictor of later PTSD symptomatology.

15.4 A 30-year-old woman is beaten and raped by a man who drove her home from a party. She calls the police immediately afterward, and the man is arrested. Although she has not sustained a concussion, she begins to lose memory of the rape in the ensuing week. By the end of the week, the woman has no memory of the rape but has become listless and depressed. The most beneficial immediate intervention for this patient would be

A. A chance to confront her assailant.
B. Hypnosis.
C. Medication.
D. Psychodynamic psychotherapy.
E. The creation of a safe environment.

The correct response is option E (p. 717). Most cases of dissociative amnesia revert spontaneously, especially when the individuals are removed from stressful or threatening situations, when they feel physically and psychologically safe, and/or when they are exposed to cues from the past (i.e., family members).

15.5 The "rule of thirds" (Kluft 1988, 1991) is a helpful guide for organizing psychotherapy (e.g., time management) for patients with dissociative identity disorder. According to this axiom, the therapist should spend the first third of the psychotherapy session assessing the patient's current mental state and life problems and defining a problem area that might benefit from retrieval into conscious memory and working through; the second third of the session helping the patient access and work through this memory; and the final third of the session helping the patient assimilate the information, regulate and modulate emotional responses, and discuss any responses to the therapist and plans for the immediate future. This rule is sometimes difficult to follow, however, because

A. The patient is too willing to talk, so the personalities can "trade" information.
B. Too much time is needed to solve day-to-day problems in the patient's life.
C. There may be resistance on the part of the therapist to adhering to the rule, because the material is compelling and interesting.
D. Abreactions occur in a way that are too structured for utility.
E. Hypnosis takes too long to do.

The correct response is option C (p. 727). There may be resistance on the part of the therapist to adhering to the rule, because the intense abreactive materials are often so compelling and interesting.

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CHAPTER 16

Sexual and Gender Identity Disorders

Select the single best response for each question.

16.1 Regarding sexual development, all of the following are true *except*

A. Gonads are initially undifferentiated.
B. Y chromosome and/or H-Y antigen are necessary for male gonadal development.
C. In utero genital development depends on the presence or absence of fetal androgen.
D. Gender identity is usually clear by age 3 years.
E. Gender role is an individual's perception and self-awareness of being male or female.

The correct response is option E (pp. 743–744). For the first few weeks of gestation, the gonads are undifferentiated. If the Y chromosome is present in the embryo, the gonads will differentiate into testes. Like the gonads, the internal and external genital structures are initially undifferentiated in the fetus. If the gonads differentiate into testes, fetal androgen (i.e., testosterone) is secreted, and these structures develop into male genitalia (epididymis, vas deferens, ejaculatory ducts, penis, and scrotum). *Gender identity* is an individual's perception and self-awareness of being male or female. *Gender role* is the behavior that an individual engages in that identifies him or her to others as being male or female (e.g., wearing dresses and makeup). Gender identity appears to develop in the early years of life and generally is established by age 3 years.

16.2 Regarding patients with gender identity disorder of adulthood, all of the following are true *except*

A. Virtually all women requesting sex reassignment surgery are attracted to women.
B. Approximately 25% of males requesting sexual reassignment are attracted to women.
C. Common personality disorders in these patients are dependent and avoidant.
D. Substance abuse is common.
E. Suicidal behavior is common.

The correct response is option C (p. 746). Virtually all of the women who apply have a sexual orientation toward women. Although male transsexuals are predominantly homosexual in orientation, approximately 25% are sexually attracted to women. Among those adults who are diagnosed as having gender identity disorder, there is a high degree of concomitant psychiatric disorder, most commonly borderline, antisocial, or narcissistic personality disorder; substance abuse; and suicidal or self-destructive behavior.

16.3 Regarding male erectile disorder, all of the following are true *except*

A. 35% of men ages 40–70 years have severe or complete erectile dysfunction.
B. 50% of men older than age 70 years have severe or complete erectile dysfunction.
C. Vasoactive injections or alpha-adrenergic blockers may be used.
D. Sildenafil promotes smooth-muscle stimulation of the corpora cavernosum.
E. An external vacuum device may be used.

The correct response is option D (pp. 753–754). Feldman et al. (1994) reported that 35% of men between the ages of 40 and 70 have severe or complete erectile dysfunction, as do 50% of men older than 70. Vasoactive injections into the corpora cavernosa can be used to treat erectile disorders. Sildenafil is now widely used in the treatment of erectile disorders; it works by releasing nitric oxide into the corpus cavernosum. This activates the enzyme guanylate cyclase, which results in increased levels of cyclic guanosine monophosphate (cGMP), producing smooth-muscle relaxation in the corpus cavernosum and allowing inflow of blood during sexual stimulation. A major noninvasive, nonpharmacological treatment for erectile dysfunction is an external vacuum device.

16.4 The most prevalent male sexual disorder is

A. Premature ejaculation.
B. Erectile dysfunction.
C. Orgasmic disorder.
D. Hypoactive sexual desire disorder.
E. Dyspareunia.

The correct response is option A (p. 756). Premature ejaculation is the most prevalent of all male sexual problems.

16.5 Regarding treatment for paraphilias, all of the following are true *except*

A. Surgical castration reliably prevents the subject from subsequently engaging in intercourse.
B. Chemical castration with cyproterone acetate (CPA) works by blockade of central and peripheral androgen receptors.
C. Selective serotonin reuptake inhibitors are often used despite a lack of prospective studies in this population.
D. Depot leuprolide has fewer physical side effects than does MPA.
E. Behavior therapies (e.g., aversive conditioning) have been associated with a reduction in sexual recidivism.

The correct response is option A (pp. 760–761). Surgical castration has been used widely in Europe with incarcerated sex offenders. However, studies have suggested that surgical castration is not an effective measure of eliminating deviant sexual behavior and that almost one-third of castrated men can still engage in intercourse. Medroxyprogesterone acetate (MPA) appears to act by blocking testosterone synthesis, whereas cyproterone acetate (CPA) acts primarily by blocking central and peripheral androgen receptors. Krueger and Kaplan (2001) reported on the successful treatment of paraphilias with depot leuprolide. This new class of antiandrogen medication has fewer side effects than MPA does. A variety of behavior therapies have been used to treat paraphilias. Various aversive conditioning methods (e.g., noxious odors) and covert sensitization have been used to reduce deviant sexual behavior.

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CHAPTER 17

Adjustment Disorders

Select the single best response for each question.

17.1 Adjustment disorders are characterized by

- A. Time-limited but not chronic stressors.
- B. Symptom resolution within 12 months of the stressor's ending.
- C. Symptom development within 3 months of the stressor's onset.
- D. Distress proportional to the stressor.
- E. Excellent diagnostic reliability and validity.

The correct response is option C (p. 767; see Table 17–2). According to DSM-IV-TR (American Psychiatric Association 2000), adjustment disorder is characterized by the development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).

17.2 A 22-year-old woman who had been fired from her job in March presents to the outpatient medical clinic in August with a 1-month history of depressed mood and insomnia. She also reports decreased appetite but no other symptoms of depression. She relates her symptoms to the job loss. The most likely diagnosis is

- A. No diagnosis.
- B. Adjustment disorder with depression.
- C. Anxiety disorder not otherwise specified.
- D. Major depression, single episode.
- E. Dysthymia.

The correct response is option B (p. 767; see Table 17–2). According to DSM-IV-TR, adjustment disorder is characterized by the development of emotional or behavioral symptoms in response to an identifiable stressor occurring within 3 months of the onset of the stressor. This patient experienced depressed mood, insomnia, and decreased appetite, all within 3 months of a stressor (loss of job). Apart from insomnia, the patient had no anxiety symptoms. She lacks a sufficient number of depressive symptoms to satisfy the diagnostic criteria for major depression, single episode. Dysthymia would be diagnosed only if the symptoms last for 2 years or more.

17.3 Which of the following statements about adjustment disorders in relation to other Axis I, Axis II, and Axis III disorders is true?

- A. Psychiatric inpatient length of stay is less for patients hospitalized with adjustment disorder than for those hospitalized with major depression.
- B. The prevalence of personality disorders is not elevated in patients with adjustment disorders.
- C. Mixed anxiety and depressive disorder (subsyndromal major depression and generalized anxiety disorder) is less chronic than adjustment disorder with mixed anxiety and depression.
- D. If a patient's symptoms from a stressor meet criteria for both depression and adjustment disorder, both diagnoses can be made.
- E. In men and women presenting with identical symptoms, women are more often diagnosed with adjustment disorder, whereas men are more often diagnosed with depression.

The correct response is option A (pp. 767–768, 771). In the MacArthur field trials on the minor depressive and anxiety disorders (Despland et al. 1995; Greenberg et al. 1995), the diagnosis of adjustment disorder was consistently associated with shorter lengths of stay compared with those associated with the major psychiatric diagnoses.

17.4 A review of the literature by Strain et al. (1998) revealed that adjustment disorder was diagnosed in hospitalized medical and surgical patients at academic hospitals at an approximate rate of

A. 2.5%.
B. 5%.
C. 12%.
D. 20%.
E. 30%.

The correct response is option C (p. 772). Strain and colleagues found that adjustment disorder was diagnosed in 125 patients (12.0%); it was the sole diagnosis in 81 patients (7.8%) and comorbid with other Axis I and Axis II diagnoses in 44 patients (4.2%).

17.5 In a 5-year follow-up study by Andreasen and Hoenk (1982), approximately what percentage of patients with adjustment disorder developed depression or alcoholism?

A. 10%.
B. 20%.
C. 30%.
D. 40%.
E. 50%.

The correct response is option B (p. 776). At 5-year follow-up in this study, 71% of the adults were completely well, 8% had developed an intervening problem, and 21% had developed major depressive disorder or alcoholism.

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CHAPTER 18

Impulse-Control Disorders Not Elsewhere Classified

Select the single best response for each question.

18.1 Intermittent explosive disorder may be associated with

A. Decreased dopamine levels.
B. Decreased serotonin levels.
C. Low testosterone levels.
D. Increased gamma-aminobutyric acid levels.
E. Increased acetylcholine levels.

The correct response is option B (p. 783). Research has implicated abnormalities in serotonergic and noradrenergic function, as well as high testosterone levels, increased dopamine levels, and increased arginine vasopressin levels, in individuals with episodic violence.

18.2 A nonpharmacological treatment indicated for kleptomania is

A. Group therapy.
B. Cognitive-behavioral psychotherapy.
C. Interpersonal psychotherapy.
D. Psychodynamic psychotherapy.
E. Systematic desensitization.

The correct response is option E (p. 787). Nonpharmacological treatments that have been used for kleptomania include systematic desensitization, assertive training, aversive conditioning, covert sensitization, self-imposed banning by shoppers, adjunctive sexual counseling for those with disturbed sexual relationships, and Shoplifters Anonymous.

18.3 A nonpharmacological treatment indicated for pyromania is

A. Aversive conditioning.
B. Cognitive-behavioral psychotherapy.
C. Interpersonal psychotherapy.
D. Psychodynamic psychotherapy.
E. Psychoanalytic psychotherapy.

The correct response is option A (p. 789). Treatment modalities that have been implemented for pyromania include behavior therapy with aversive conditioning, positive reinforcement, social skills training, and use of relapse prevention plans.

18.4 A patient who fits the antisocial–impulsive (action) subtype of pathological gambling

A. Is most likely a female.
B. Experiences a euphoric state while gambling.
C. Is generally passive in day-to-day life.
D. Is less manipulative than the obsessive–dependent (escape) subtype.
E. Is stingy about spending money.

The correct response is option B (p. 790). Action gamblers are predominantly male and achieve a euphoric state through gambling.

18.5 Which of the following comorbid disorders is most likely to be present in a patient with trichotillomania?

A. Body dysmorphic disorder.
B. Eating disorder.
C. Mood disorder.
D. Psychotic disorder.
E. Substance abuse.

The correct response is option C (p. 795; Table 18–8). As shown in table ("Lifetime prevalence of psychiatric disorders of chronic hair pullers"), a number of psychiatric disorders are often comorbid with trichotillomania. The most common comorbid psychiatric conditions are mood disorders, followed by anxiety disorders and personality disorders.

Lifetime prevalence of psychiatric disorders of chronic hair pullers

Diagnosis	% of sample
Trichotillomania	83[a]
Mood disorders	65
Anxiety disorders	57
Personality disorders	25–55
Body dysmorphic disorder	23
Substance abuse	22
Eating disorders	20
Psychotic disorders	2
No disorder (except trichotillomania)	18

[a] Not all individuals had both an increasing sense of tension before pulling out the hair and gratification or relief when pulling out the hair (both are required in DSM-IV-TR).

CHAPTER 19

Personality Disorders

Select the single best response for each question.

19.1 Personality disorder patients have elevated rates of all of the following *except*

A. Separation and divorce.
B. Unemployment.
C. Perpetration of child abuse.
D. Positive response to pharmacotherapy for mood disorders.
E. Attempted and completed suicide.

The correct response is option D (p. 804). Individuals with personality disorders have elevated rates of separation, divorce, child custody proceedings, unemployment, homelessness, and perpetration of child abuse. They also have increased rates of accidents; police contacts; emergency department visits; medical hospitalization; violence, including homicide; self-injurious behavior; attempted suicide; and completed suicide. Moreover, patients with depressive disorders, bipolar disorder, panic disorder, obsessive-compulsive disorder, and substance abuse often respond less well to pharmacotherapy when they have a comorbid personality disorder.

19.2 The three personality disorder clusters (A, B, and C) were first introduced in

A. DSM-I.
B. DSM-II.
C. DSM-III.
D. DSM-III-R.
E. DSM-IV.

The correct response is option C (p. 805). Since DSM-III, the personality disorders have been grouped into three clusters: the odd or eccentric cluster (schizotypal, schizoid, and paranoid); the dramatic, emotional, or erratic cluster (borderline, histrionic, narcissistic, and antisocial); and the anxious or fearful cluster (avoidant, dependent, and obsessive-compulsive).

19.3 The five-factor model of personality of Costa and McCrae includes which of the following domains?

A. Neuroticism, Extraversion, Openness, Agreeableness, and Conscientiousness.
B. Neuroticism, Extraversion, Openness, Agreeableness, and Harm Avoidance.
C. Openness, Agreeableness, Conscientiousness, Harm Avoidance, and Novelty Seeking.
D. Agreeableness, Neuroticism, Extraversion, Openness, and Persistence.
E. Agreeableness, Conscientiousness, Novelty Seeking, Persistence, and Harm Avoidance.

The correct response is option A (p. 807; see Table 19–2). Costa and McCrae's (1990) model of personality encompasses five factor domains: Neuroticism, Extraversion, Openness, Agreeableness, and Conscientiousness.

19.4 Cloninger et al.'s seven-factor model of personality includes all of the following temperaments *except*

A. Harm avoidance.
B. Novelty seeking.
C. Reward dependence.
D. Persistence.
E. Openness.

The correct response is option E (p. 808; see Table 19–3). The Cloninger et al. (1993) model of personality contains four "temperament" dimensions (Harm avoidance, Novelty seeking, Reward dependence, and Persistence) and three "character" dimensions (Self-directedness, Cooperative, and Self-transcendent).

19.5 Regarding biological markers for schizotypal personality disorder, all of the following have been reported *except*

A. Increased ventricular–brain ratio.
B. Increased cerebrospinal fluid (CSF) volume.
C. Decreased CSF homovanillic acid (HVA).
D. Impaired smooth-pursuit eye movements.
E. Impaired performance on tests of executive functions.

The correct response is option C (p. 814). At least some forms of schizotypal personality disorder involve biological abnormalities characteristic of schizophrenia—for example, an increased ventricular–brain ratio on computed tomography scan; increased cerebrospinal fluid volume not attributable to ventricular volume; higher cerebrospinal fluid homovanillic acid concentrations; impaired smooth-pursuit eye movements; and impaired performance on tests of executive function and other tests of visual or auditory attention (e.g., Wisconsin Card Sorting Test, backward masking task, continuous performance task, sensory gating tests), suggesting altered precortical functioning.

19.6 Regarding narcissistic personality disorder, all of the following are true *except*

A. Depression can often follow an episode of rejection, defeat, or criticism.
B. Patients are distant within relationships, attempting to maintain an illusion of self-sufficiency.
C. Patients tend to be exploitative of others in pursuit of their "special" goals.
D. Patients are likely to have had their childhood fears, failures, or dependency needs answered with criticism, disdain, or neglect.
E. Cognitive-behavioral therapy is preferred over psychodynamically oriented psychotherapy.

The correct response is option E (pp. 820–821). Because persons with narcissistic personality disorder have grandiose self-esteem, they are vulnerable to intense reactions when their self-image is damaged. They respond with strong feelings of hurt or anger to even small slights, rejections, defeats, or criticisms. As a result, persons with narcissistic personality disorder usually go to great lengths to avoid exposure to such experiences and, when that fails, react by becoming devaluative or rageful. Serious depression can ensue, which is the usual precipitant for their seeking clinical help. In relationships, narcissistic persons are often quite distant, try to sustain an illusion of self-sufficiency, and may exploit others for self-serving ends. Like persons with antisocial personality disorder, those with narcissistic personality disorder are capable of exploiting others but usually rationalize their behavior on the basis of the specialness of their goals or their personal virtue. Reconstructions based on developmental history and observations in psychoanalytic treatment indicate that this disorder develops in persons whose fears, failures, or dependency needs were met with criticism, disdain, or neglect during their childhood years. Individual psychodynamic psychotherapy, including psychoanalysis, is the cornerstone of treatment for persons with narcissistic personality disorder.

19.7 Regarding avoidant personality disorder, all of the following are true *except*

A. Presentation must be differentiated from schizoid personality disorder.
B. Symptoms can overlap with social phobia.
C. Patients demonstrate restraint within intimate relationships.
D. Monoamine oxidase inhibitors and selective serotonin reuptake inhibitors are recommended.
E. Patients readily engage in treatment.

The correct response is option E (pp. 821–822). Although schizoid personality disorder also involves social isolation, the schizoid person does not desire relationships, whereas the avoidant person desires relationships but avoids them out of anxiety and fears of humiliation and rejection. Because of their excessive fear of rejection and criticism and their reluctance to form relationships, persons with avoidant personality disorder may be difficult to engage in treatment. Promising preliminary data suggest that avoidant personality disorder may improve with treatment with monoamine oxidase inhibitors or serotonin reuptake inhibitors.

19.8 Regarding obsessive-compulsive personality disorder, all of the following are true *except*

A. It is referred to as "anancastic" personality disorder in ICD-10.
B. Patients frequently report the cognition "I should."
C. Psychological defenses include perfectionism and extreme need for control.
D. The psychotherapist should be reserved and distant and avoid excessive "activity" in treatment.
E. Psychotherapists should focus on the expression of feelings rather than the gathering of facts.

The correct response is option D (pp. 824–825). In European psychiatry, obsessive-compulsive personality disorder has been referred to as *anancastic personality disorder*, a term coined by Kretschmer and Schneider in the 1920s and still used in ICD-10. As Shapiro (1965) pointed out, the most characteristic thought of obsessive-compulsive persons is "I should"—a phrase that aptly reflects these individuals' severe superego and captures their overly high standards, drivenness, and excessive conscientiousness, perfectionism, rigidity, and devotion to work and duties.

The psychotherapist should be active and involved. Because persons with obsessive-compulsive personality disorder have difficulty dealing with emotions, a major focus of therapy is to help the patient express and understand his or her feelings.

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CHAPTER 20

Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence

Select the single best response for each question.

20.1 Genetic studies of attention-deficit/hyperactivity disorder (ADHD) reveal that

A. Biological parents have less psychopathology than adoptive parents.
B. Family members of ADHD patients have an increased prevalence of mood disorders.
C. Family members of ADHD patients have a decreased prevalence of anxiety disorders.
D. Family members of ADHD patients have an increased prevalence of schizophrenia.
E. Other relatives of ADHD patients have as much psychopathology as family members of ADHD patients.

The correct response is option B (p. 839). Family members of children with ADHD show an increased prevalence of ADHD, conduct disorder and antisocial personality disorder, mood disorders, anxiety disorders, and substance abuse.

20.2 ADHD symptoms may be caused by

A. Damage to the cerebellum.
B. Diabetes mellitus.
C. Exposure to aluminum.
D. High birth weight.
E. Streptococcal infections.

The correct response is option E (p. 840). Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS), such as obsessive-compulsive disorder and Tourette's disorder, may present with ADHD symptoms.

20.3 An integrated model of ADHD by Barkley (1997a, 1997b) posited that the primary problem for patients is

A. Deficient response inhibition.
B. Dysregulation of serotonin.
C. Dysregulation of gamma-aminobutyric acid (GABA).
D. Enhanced semantic processing.
E. Impaired communication between dopamine, norepinephrine, and serotonin neurons.

The correct response is option A (p. 844). Barkley's integrated model of ADHD postulated that deficient response inhibition is the core feature of ADHD and is central to the development and proper working of the four executive neuropsychological functions: 1) working memory; 2) self-regulation of affect, motivation, and arousal; 3) internalization of speech; and 4) reconstitution (behavioral analysis and synthesis).

20.4 In cases of possible ADHD, lack of response to psychostimulants may indicate the presence of another underlying disorder. Each of the following disorders might be worsened by psychostimulants *except*

A. Bipolar disorder.
B. Major depressive disorder.

C. Epilepsy.
D. Generalized anxiety disorder.
E. Schizophrenia.

The correct response is option B (p. 850). Some patients do not experience therapeutic effects from psychostimulants. Factors to be considered in these cases include the possibility of a comorbid psychiatric condition, given that anxiety disorders or symptoms, bipolar disorder, and schizophrenia, among other disorders, are aggravated by psychostimulants.

20.5 Few scales are available for the assessment of ADHD in adults. Which of the following instruments is useful in this regard?

A. Achenbach Child Behavioral Checklist.
B. Child Attention/Activity Profile.
C. Continuous Performance Test.
D. The Home Situations Questionnaire.
E. Wender Utah Rating Scale.

The correct response is option E (p. 853). The best available instrument for use in adults is the Wender Utah Rating Scale, which is also useful in assessing ADHD symptoms in children.

20.6 Clinical features of conduct disorder may include all of the following *except*

A. Breaking and entering.
B. Impulsivity.
C. Intimidation of others.
D. Physical cruelty to others.
E. Running away.

The correct response is option B (pp. 855–856). A crucial feature of conduct disorder is the absence of impulsivity. All of the other clinical features listed are commonly found in conduct disorder.

20.7 A risk factor for conduct disorder is

A. Above-average intelligence.
B. Coming from a single-parent home.
C. Family separation.
D. Inadequate supervision at home.
E. Small family size.

The correct response is option D (p. 857). Adequate supervision at home, especially when parents are away, has been shown to reduce the risk of conduct disorder.

20.8 A 9-year-old boy is brought into an outpatient medical clinic because of hostile behavior manifested by losing his temper, arguing with adults, defying rules at home, and purposely annoying others. At school, he often defies or refuses to comply with the teacher's rules. The primary care physician does not have time to ask more questions but does discover that the boy often blames others for his misbehavior. The most likely diagnosis, on the basis of this limited information, is

A. Conduct disorder, childhood onset.
B. Attention-deficit/hyperactivity disorder.
C. Reactive attachment disorder of early childhood.
D. Oppositional defiant disorder.
E. Asperger's disorder.

The correct response is option D (p. 863; see Table 20–7). Oppositional defiant disorder is characterized by a pattern of negativistic, hostile, and defiant behavior lasting at least 6 months, during which four (or more) of the following are present: often loses temper, often argues with adults, often actively defies or refuses to comply with adults' requests or rules, often deliberately annoys people, often blames others for his or her mistakes or misbehavior, is often touchy or easily annoyed by others, is often angry and resentful, and is often spiteful or vindictive.

20.9 A survey of caregivers for child and adult patients with mental retardation conducted by Birch et al. revealed that the most significant caregiving burden is

A. Cleaning.
B. Lifting the child.
C. Shopping.
D. Watching the child on school holidays.
E. Dressing the child.

The correct response is option D (p. 890; see Figure 20–3). The most significant burden, according to Birch et al.'s (1970) survey, was watching the child on school holidays (70%), followed by watching the child on weekends (60%), lifting the child (40%), dressing the child (30%), cleaning (20%), and shopping (10%).

20.10 Pharmacotherapy for autistic disorder can help most by

A. Facilitating exploration.
B. Increasing adaptive skills.
C. Increasing self-reliance.
D. Promoting socialization.
E. Reducing perseverative behaviors.

The correct response is option E (p. 898). The symptoms most amenable to pharmacotherapy include perseverative behaviors (comparable to obsessive-compulsive symptoms), depressive disorders, aggressivity, impulsivity, destructiveness, bipolar disorders, anxiety, hyperactivity, hypoactivity, pica, and self-injurious behaviors.

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CHAPTER 21

Sleep Disorders

Select the single best response for each question.

21.1 Which of the following statements is true about rapid eye movement (REM) sleep?

A. It is driven by the ascending cholinergic cells of the pedunculopontine tegmental (PPT) nucleus and the lateral dorsal tegmental (LDT) nucleus.
B. The LDT nucleus receives stimulatory projections from the serotonergic cells of the dorsal raphe nucleus.
C. The limbic forebrain becomes deactivated.
D. Input from amygdala projections are decreased in patients with major depression.
E. Muscle atonia is modulated by norepinephrine.

The correct response is option A (p. 976). REM sleep onset is driven by ascending cholinergic cells of both the PPT nucleus and the LDT nucleus. These cells receive inhibitory projections from the serotonergic cells of the dorsal raphe nuclei and the noradrenergic cells of the locus coeruleus. In addition, areas of the limbic forebrain become activated during REM sleep.

21.2 The timing of the daily sleep–wake cycle is mainly under the control of the

A. Dorsal tegmental nucleus.
B. Locus coeruleus.
C. Raphe nucleus.
D. Pedunculopontine nucleus.
E. Suprachiasmatic nucleus.

The correct response is option E (p. 976). The timing of our daily sleep–wake cycle is mainly under the control of the suprachiasmatic nucleus in the hypothalamus, which establishes a daily, or circadian, rhythm.

21.3 A 29-year-old woman presents to her primary care physician with a chief complaint of insomnia. The history reveals a stressful time at work that results in her worrying about issues at bedtime. After providing education and relaxation training for the patient, the physician decides to prescribe a hypnotic agent. All of the following have a rapid onset *except*

A. Flurazepam.
B. Temazepam.
C. Triazolam.
D. Zaleplon.
E. Zolpidem.

The correct response is option B (p. 978; see Table 21–1). Of the commonly used hypnotic agents, only temazepam (Restoril) does not have a rapid onset.

21.4 Sleepiness is more alarming to patients than insomnia, because its symptoms produce a higher degree of

A. Anxiety.
B. Depression.
C. Medical problems.
D. Psychosocial impairment.
E. Utilization of medical services.

The correct response is option D (p. 979). Sleepiness relates to the propensity to sleep, such as after sleep deprivation. Clinically, it is more alarming than insomnia because it causes a higher degree of psychosocial impairment as well as a high rate of automobile and occupational accidents.

21.5 Which maintenance treatment for chronic insomnia has been reported to produce the greatest patient satisfaction?

A. Antidepressant medication.
B. Counseling on sleep hygiene.
C. Education.
D. Hypnotic medication.
E. Relaxation therapies.

The correct response is option E (p. 981). Various relaxation therapies—such as hypnosis, meditation, deep breathing, and progressive muscle relaxation—can be helpful. These techniques, in contrast to the use of hypnotics, are not immediately beneficial but require several weeks of practice to improve sleep. Success depends on a high degree of motivation in patients, who must devote considerable time to practicing the techniques. Those who succeed in learning these techniques, however, have greater satisfaction with maintenance treatment than do patients who chronically use hypnotics. Furthermore, responders to behavioral interventions show sustained benefits after 6 months.

CHAPTER 22

Eating Disorders

Select the single best response for each question.

22.1 In anorexia nervosa, all of the following are true *except*

A. Patients disproportionately decrease their consumption of high-carbohydrate foods.
B. Patients disproportionately decrease their intake of foods with high fat content.
C. Many patients exhibit obsessions regarding cleanliness and engage in compulsive cleaning.
D. Patients have a markedly decreased interest in sexual activity.
E. Amenorrhea is due solely to weight loss.

The correct response is option E (pp. 1003–1004). Persons with anorexia nervosa lose weight by drastically reducing their total food intake and disproportionately decreasing the intake of high-carbohydrate and fatty foods. Obsessive-compulsive behavior often develops after the onset of anorexia nervosa. An obsession with cleanliness, an increase in housecleaning activities, and a more compulsive approach to studying are not uncommonly observed in these patients. Poor sexual adjustment is frequently present in patients with anorexia. Many adolescent patients with anorexia have delayed psychosocial sexual development, and adults often have a markedly decreased interest in sex with the onset of anorexia nervosa. Amenorrhea can appear before noticeable weight loss has occurred.

22.2 Systemic complications of anorexia nervosa include

A. Leukocytosis.
B. Hyperkalemic alkalosis.
C. Hyperchloremia.
D. Decreased serum bicarbonate levels.
E. Cardiac arrhythmias.

The correct response is option E (p. 1004). We often find abnormalities in hematopoiesis, such as leukopenia and relative lymphocytosis, in acutely emaciated anorexic patients. Individuals with anorexia nervosa who engage in self-induced vomiting or who abuse laxatives and diuretics are at risk of developing hypokalemic alkalosis. These patients often are found to have elevated serum bicarbonate levels, hypochloremia, and hypokalemia. Patients with electrolyte disturbances experience physical symptoms of weakness and lethargy and, at times, have cardiac arrhythmias.

22.3 Poorer outcome in anorexia nervosa is associated with all of the following *except*

A. Longer duration of illness.
B. Younger age at onset.
C. History of psychiatric hospitalization.
D. Poor childhood social adjustment.
E. Premorbid personality dysfunction.

The correct response is option B (p. 1005). Generally speaking, poor outcome is associated with longer duration of illness, older age at onset, previous admissions to psychiatric hospitals, poor childhood social adjustment, premorbid personality difficulties, and disturbed relationships between patients and other family members.

22.4 In bulimia nervosa

A. Illness onset typically follows a period of dieting.
B. The majority of patients abuse diuretics.
C. The average binge episode lasts more than 2 hours.

D. Comorbid depressive symptoms are seen in a minority of patients.
E. Impulsivity in other spheres of behavior is infrequent.

The correct response is option A (p. 1011). Bulimia nervosa usually begins after a period of dieting lasting from a few weeks to a year or longer. The dieting may or may not have been successful in achieving weight loss. Most binge-eating episodes are followed by self-induced vomiting. Episodes are less frequently followed by use of laxatives. A minority of bulimic patients use diuretics for weight control. The average length of a bingeing episode is about 1 hour. Most bulimic patients have depressive signs and symptoms. They also have problems with interpersonal relationships, self-concept, and impulsive behaviors and show high levels of anxiety and compulsivity.

22.5 Medical complications of bulimia nervosa include all of the following *except*

A. Increased or decreased bicarbonate.
B. Hypochloremia.
C. Hyperkalemia.
D. Increased serum amylase.
E. Cardiomyopathy.

The correct response is option C (pp. 1011–1012). Bulimia patients have electrolyte abnormalities, including elevated serum bicarbonate levels, hypochloremia, hypokalemia, and, in a few cases, low serum bicarbonate levels, indicating a metabolic acidosis. Parotid gland enlargement associated with elevated serum amylase levels is commonly observed in patients who binge and vomit. Cardiac failure caused by cardiomyopathy from ipecac intoxication is a medical emergency that is being reported with increasing frequency; it usually results in death.

22.6 Antidepressants effective in the treatment of bulimia nervosa include all of the following *except*

A. Desipramine.
B. Imipramine.
C. Phenelzine.
D. Fluoxetine.
E. Bupropion.

The correct response is option E (pp. 1014–1016; see Table 22–8). Antidepressants found to have efficacy in controlled treatment studies of bulimia nervosa include desipramine, imipramine, nortriptyline, phenelzine, and fluoxetine.

CHAPTER 23

Pain Disorders

Select the single best response for each question.

23.1 According to the International Association for the Study of Pain classification of chronic pain, psychological factors can be addressed on which of the following axes?

A. Axis I—Regions and Axis II—Systems.
B. Axis II—Systems and Axis V—Etiology.
C. Axis II—Systems and Axis III—Temporal characteristics of pain.
D. Axis IV—Patient's statement of intensity and Axis V—Etiology.
E. Axis II—Systems and Axis IV—Patient's statement of intensity.

The correct response is option B (p. 1024). The schema developed by the Task Force on Taxonomy of the International Association for the Study of Pain (Merskey and Bogduk 1994) provides for comments on psychological factors on both the second axis, where psychiatric illness can be coded under the nervous system, and the fifth axis, where possible etiologies can include "psychophysiological" and "psychological."

23.2 In regard to the association of pain with depression or anxiety, all of the following are true *except*

A. Pain often precedes the onset of depression.
B. Preexisting depression may predispose to chronic pain.
C. Mood disorders are more common in first-degree relatives of patients with chronic pain.
D. Pain is an infrequent presenting symptom of depression.
E. Thirty percent of patients who report chest pain despite having normal coronary arteries are found to meet criteria for panic disorder.

The correct response is option D (p. 1026). In regard to associations between pain and depression, it is often assumed that patients develop depression as a response to pain, although other opinions on this issue have been voiced. Blumer and Heilbronn (1982) suggested that the associated mental disorder may precede the pain and possibly predispose the patient to it; they described the pain-prone individual whose pain is a form of masked depression. Some studies indicate that depressive disorders may be more common in the first-degree relatives of people with chronic pain, which suggests a possible environmental or genetic predisposition to pain. Other research suggests that depression is secondary to pain or that these two problems may coexist either independently or as the result of a common psychological or neurochemical pathway. Pain is a very common presenting symptom of depression and in fact may often be the only symptom.

In regard to associations between pain and anxiety, Beitman et al. (1988, 1989) observed that more than 30% of patients with chest pain and normal coronary arteries by cardiac catheterization met criteria for panic disorder.

23.3 The opioid with a unique risk for lethal interaction with monoamine oxidase inhibitors (MAOIs) is

A. Propoxyphene.
B. Oxycodone.
C. Meperidine.
D. Dilaudid.
E. Morphine.

The correct response is option C (p. 1034). Psychiatrists should be aware that meperidine—

apparently alone among the opioid analgesics—can have a lethal interaction with MAOIs and can increase the risk of postoperative delirium.

23.4 In the United States, the only opioid available in transdermal and transmucosal forms is

A. Morphine.
B. Methadone.
C. Fentanyl.
D. Hydromorphone.
E. Codeine.

The correct response is option C (p. 1036). Fentanyl is available in two preparations not currently available for other opioids: transdermal and transmucosal.

23.5 The only nonsteroidal anti-inflammatory drug (NSAID) available in the U.S. in a parenteral preparation is

A. Valdecoxib (Bextra).
B. Sulindac (Clinoril).
C. Rofecoxib (Vioxx).
D. Naproxen (Naprosyn).
E. Ketorolac (Toradol).

The correct response is option E (p. 1037; see Table 23–10). Ketorolac (Toradol) is the only NSAID available in parenteral form in the United States.

23.6 Regarding the use of antidepressants for pain, which of the following is true?

A. Among tricyclic antidepressants (TCAs), amitriptyline has repeatedly been shown to have the strongest analgesic effect.
B. Selective serotonin reuptake inhibitors (SSRIs) have been shown to have superior analgesic effects compared with TCAs.
C. SSRIs are the first-line agents for neuropathic pain.
D. All of the TCAs are equally analgesic.
E. The optimal analgesic dose of extended-release venlafaxine (Effexor XR) is between 75 and 150 mg/day.

The correct response is option D (p. 1038). The TCAs are considered the first-line drugs for treatment of pain related to neuropathies, including postherpetic neuralgia and diabetic neuropathy. Although amitriptyline is still widely believed to be the TCA with the strongest analgesic effect, there is little literature to support this. All of the TCAs appear to be equally analgesic.

The few studies that have examined the analgesic effects of the SSRIs indicate that their analgesic properties are inferior to those of the TCAs and may not be markedly better than placebo.

The optimal analgesic dose of extended-release venlafaxine (Effexor XR) has yet to be determined; however, King [chapter author] has recommended a target dosage of 225–375 mg/day.

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CHAPTER **24**

Psychopharmacology and Electroconvulsive Therapy

Select the single best response for each question.

24.1 Clinically meaningful plasma levels have been established for which of the following tricyclic antidepressants (TCAs)?

A. Imipramine, desipramine, and nortriptyline.
B. Desipramine, nortriptyline, and doxepin.
C. Nortriptyline, amitriptyline, and doxepin.
D. Doxepin, amitriptyline, and protriptyline.
E. Amitriptyline, protriptyline, and amoxapine.

The correct response is option A (p. 1053). Clinically meaningful plasma levels are available for imipramine, desipramine, and nortriptyline. For imipramine, the combined sum of the plasma levels of imipramine and the desmethyl metabolite (desipramine) should be greater than 200 ng/mL. Plasma levels of desipramine should be greater than 125 ng/mL. A therapeutic window has been found for nortriptyline, with optimal response observed between 50 and 150 ng/mL. These therapeutic levels are based on steady-state concentrations, which are reached after 5–7 days on the medication. For monitoring purposes, blood should be drawn approximately 10–14 hours after the last dose of medication.

24.2 Extrapyramidal symptoms (EPS), akathisia, and tardive dyskinesia are seen with which antidepressant?

A. Imipramine.
B. Desipramine.
C. Doxepin.
D. Amoxapine.
E. Nortriptyline.

The correct response is option D (p. 1055). Amoxapine, which has a mild neuroleptic effect, can cause EPS, akathisia, and even tardive dyskinesia. For this reason, we do not recommend that amoxapine be prescribed as a first-line treatment for depression.

24.3 Which of the following statements is true in regard to selective serotonin reuptake inhibitors (SSRIs)?

A. Intolerance to one SSRI predicts intolerance to others.
B. Citalopram has a half-life of 24 hours, with clinically significant metabolites.
C. Fluvoxamine is U.S. Food and Drug Administration (FDA) approved for major depression and is effective at dosages of 50–150 mg/day.
D. In general, SSRIs exhibit a positive dose–response curve.
E. Trials of SSRIs for treatment of obsessive-compulsive disorder (OCD) generally require higher dosages and a longer period than for treatment of mood disorders (e.g., 8–12 weeks).

The correct response is option E (pp. 1056–1057). Because the SSRIs are structurally and, in some cases, clinically distinct, allergy to one SSRI does not predict allergy to another. Citalopram has a half-life of 35 hours and no clinically significant metabolites. The manufacturer of fluvoxamine has not pursued FDA approval for the treatment of depression in the United States (fluvoxamine is approved only for the treatment of OCD); however, this agent is an effective antidepressant at 50–150 mg/day.

When used for the treatment of depression, the SSRIs have a flat dose–response curve, meaning that higher dosages tend not to be more effective than standard dosages (although an occasional patient will respond better to higher dosages). Premature escalation of the SSRI dosage when treating a patient with depression is most likely to result in increased or additional side effects without improved antidepressant efficacy. Therefore, it is recommended that the usual therapeutic dosage be maintained for 4 weeks. If no improvement is seen at the end of that time, a trial of a higher dose may be warranted. If a partial response is evident at 4 weeks, the dosage should remain constant for an additional 2 weeks, because improvement in response to the initial dosage may continue.

In comparison with SSRI treatment of depression, SSRI treatment of OCD requires a longer period and often higher dosages to assess efficacy. The recommended duration of a therapeutic trial of an SSRI for OCD is 8–12 weeks.

24.4 Psychiatric conditions that often eventually require higher doses of SSRIs than doses typical for major depression include all of the following *except*

A. OCD.
B. Bulimia nervosa.
C. Posttraumatic stress disorder.
D. Borderline personality disorder.
E. Late luteal phase dysphoric disorder.

The correct response is option E (p. 1057). In the treatment of panic disorder, data indicate that 40–60 mg/day of paroxetine is more efficacious than lower dosages. However, available data indicate that the other SSRIs are effective for the treatment of panic disorder at their typical antidepressant dosages. Interestingly, late luteal phase dysphoric disorder can be treated with medication administered only during the symptomatic period before menses. Fluoxetine is effective in the treatment of bulimia at a dosage of 60 mg/day. Although the other SSRIs also may be effective for the treatment of bulimia, dosing guidelines are not yet available. The use of SSRIs to attenuate symptoms associated with borderline personality disorder and PTSD may require relatively higher dosages.

24.5 Which of the following statements is true in regard to bupropion?

A. It has an inactive hydroxymetabolite.
B. Because of its dopaminergic effects, it may be useful in depression in Parkinson's disease.
C. It has not been advocated for use in attention-deficit/hyperactivity disorder (ADHD).
D. It is recommended for treatment of panic disorder.
E. It is effective in the treatment of OCD.

The correct response is option B (pp. 1059–1060). Bupropion is metabolized to hydroxybupropion, which appears to be the active entity. Hydroxybupropion inhibits the reuptake of norepinephrine and dopamine—hence the designation dopamine–norepinephrine reuptake inhibitor (DNRI). Because bupropion facilitates dopamine transmission, many clinicians preferentially use this agent to treat depression in patients with Parkinson's disease. Several small clinical trials have indicated that bupropion may be beneficial in the treatment of ADHD. Unfortunately, bupropion is not effective in the treatment of panic disorder or OCD, and clinical experience suggests that it has less ability than the SSRIs to attenuate symptoms of general anxiety.

24.6 Which of the following statements is true in regard to venlafaxine?

A. It is highly protein bound.
B. It is unlikely to inhibit cytochrome P450 enzymes.
C. It has a flat dose–response curve.
D. It is not FDA approved for generalized anxiety disorder (GAD).
E. It has a high risk of inducing hypertension at low doses.

The correct response is option B (p. 1061). Venlafaxine is 27% protein bound, a proportion substantially lower than that for any other antidepressant. Venlafaxine is unlikely to inhibit cytochrome P450 enzymes, a feature that further decreases the likelihood of drug interactions. The extended-release formulation of venlafaxine allows for once-a-day dosing. Blood pressure elevation may occur at higher dosages. Unlike the SSRIs, venlafaxine shows a positive dose–response relationship; patients with mild depression may respond to lower doses, whereas patients with more severe or recurrent depression may respond better to higher doses.

24.7 Which of the following statements is true in regard to mirtazapine?

A. It exhibits agonism of alpha-2 noradrenergic auto- and heteroreceptors.
B. It antagonizes postsynaptic 5-HT_{2B}, 5-HT_3, and H_2 receptors.
C. It antagonizes postsynaptic 5-HT_{2A}, 5-HT_3, and H_1 receptors.
D. It has minimal activity at alpha-1 and muscarinic receptors.
E. It has several problematic cytochrome P450 enzyme inhibitory effects.

The correct response is option C (p. 1063). Mirtazapine facilitates central serotonergic and noradrenergic transmission by antagonizing alpha-2 noradrenergic autoreceptors and heteroreceptors. In addition, mirtazapine antagonizes postsynaptic 5-HT_{2A}, 5-HT_3, and H_1 receptors. 5-HT_{2A} antagonism may be related to the antidepressant properties of this drug and likely accounts for the low occurrence of drug-induced sexual dysfunction. 5-HT_3 antagonism is thought to prevent nausea. Antagonism of H_1 receptors may account for the side effects of sedation and weight gain. Mirtazapine has moderate activity at alpha-1 receptors and muscarinic receptors. In addition, mirtazapine is unlikely to be associated with cytochrome P450–mediated drug interactions.

24.8 Which of the following atypical antipsychotics have the lowest rates of EPS and thus are favored in the treatment of psychosis in Parkinson's disease?

A. Clozapine and ziprasidone.
B. Quetiapine and clozapine.
C. Risperidone and quetiapine.
D. Olanzapine and ziprasidone.
E. Quetiapine and olanzapine.

The correct response is option B (p. 1085). Clozapine and quetiapine have the least EPS liability and consequently are recommended for treatment of psychosis in patients with Parkinson's disease.

24.9 Which of the following atypical antipsychotics is associated with a persistently increased prolactin level?

A. Risperidone.
B. Olanzapine.
C. Quetiapine.
D. Ziprasidone.
E. Clozapine.

The correct response is option A (p. 1086). With the notable exception of risperidone, the atypical antipsychotics produce substantially less hyperprolactinemia than do conventional agents.

24.10 Which of the following atypical antipsychotics is associated with the least weight gain?

A. Risperidone.
B. Olanzapine.
C. Quetiapine.
D. Ziprasidone.
E. Clozapine.

The correct response is option D (p. 1102). Ziprasidone produces less weight gain than do other atypical antipsychotic agents.

CHAPTER 25

Brief Dynamic Individual Psychotherapy

Select the single best response for each question.

25.1 Brief dynamic individual psychotherapy, compared with other models of individual psychotherapy, includes all of the following features *except*

A. Limited focus.
B. Termination.
C. Limited time.
D. Selection criteria.
E. Less therapist activity.

The correct response is option E (p. 1156; see Table 25–1). Brief psychodynamic psychotherapy is defined by the following qualities:

- Limited focus (and limited goals)
- Limited time for treatment
- Well-defined selection criteria
- Increased therapist activity
- Therapeutic alliance
- Rapid assessment/prompt intervention
- Focus on termination
- Optimism
- Contract
- Analytic concepts
- Analytic techniques

25.2 General guidelines for the development of a psychodynamic focus include all of the following *except*

A. Gather historical data while letting the patient tell his own story.
B. Study the patient's characteristic defensive patterns.
C. Delay responding to negative transference reactions.
D. Examine the countertransference.
E. Be attentive to the emergence of resistances.

The correct response is option C (p. 1157; see Table 25–3). As set forth by Wolberg (1980), general principles for developing a psychodynamic focus are as follows:

- Gather historical material and other data, but let the patient tell his or her own story.
- Study the patient's characteristic defensive patterns.
- Be sensitive to how present patterns have roots in the past.
- Watch for transference patterns; deal with negative transference reactions rapidly and supportively.
- Examine possible countertransference feelings and behavior for clues as to repetitive dysfunctional patterns.
- Continually look for resistances that threaten to block progress.

25.3 In regard to the management of time limits and boundaries in brief dynamic individual psychotherapy, therapists are experimenting with which of the following variations?

A. Scheduling frequent initial sessions with more intermittent later sessions.
B. Varying the duration of each therapy session.
C. Offering several courses of brief therapy throughout the life cycle.
D. None of the above.
E. All of the above.

The correct response is option E (p. 1158). Although it is most customary for psychodynamically oriented short-term therapists to use the traditional weekly 50-minute "hour," many clinicians are experimenting with the frequency of sessions (e.g., frequent initial sessions with more intermittent later sessions), the duration of each therapy session (e.g., the 20-minute "hour"), and even the number of successive brief therapies (e.g., intermittent brief therapy throughout the life cycle).

25.4 Selection criteria for brief dynamic therapy may include all of the following *except*

A. Adequate ego strength.
B. High level of motivation.
C. History of meaningful relationships.
D. Generalized psychological problems or multiple symptom clusters.
E. Adequate intelligence and psychological sophistication.

The correct response is option D (p. 1159). The authors credited with bringing brief dynamic psychotherapy into the modern therapeutic area (Davanloo 1980; Malan 1979; Mann 1973; Sifneos 1987) specified fairly stringent suitability characteristics:

- Appropriate ego strength
- Ability to become rapidly involved in and contribute to treatment
- Adequate motivation
- A history of meaningful relationships
- Adequate intelligence or psychological sophistication
- A relatively circumscribed problem or symptom presentation (as opposed to wide-ranging difficulties in many aspects of the patient's life)

25.5 Contraindications to brief psychodynamic therapy include all of the following *except*

A. Psychotic illness.
B. Bipolar disorder.
C. Drug dependence.
D. Impulse-control disorders.
E. Avoidant personality disorder.

The correct response is option E (p. 1159). Short-term dynamic theorists have specified relatively consistent exclusion criteria, such as presence of psychosis, major affective disorders (especially bipolar disorder), drug use, suicidal tendencies (and other acting out) or impulsive tendencies, organic disorders, and some personality disorders (e.g., borderline personality disorder, especially in patients with histories of acting out; schizoid personality disorder when interpersonal unresponsiveness on the part of the patient is noted).

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CHAPTER 26

Psychoanalysis, Psychoanalytic Psychotherapy, and Supportive Psychotherapy

Select the single best response for each question.

26.1 Individual psychotherapy

A. May be used with any patient.
B. Is best measured as beneficial when the patient feels there are no problems.
C. Seeks to identify the characteristic patterns of behavior of the patient that are causing problems in living.
D. Is as efficacious alone as in combination with antidepressant medication for depression.
E. Requires behavioral change to take place.

The correct response is option C (p. 1178; see Table 26–1). Psychodynamic psychotherapy consists of an interaction (primarily verbal) between two persons—the help seeker and an expert—who work together to identify the patient's characteristic problems in living, with the hope of achieving behavioral change.

26.2 The primary goal of psychoanalysis is to

A. Increase happiness by relieving conflicts.
B. Produce strong affects to "get out" conflicts.
C. Problem-solve practical day-to-day problems.
D. Increase awareness of sexual impulses.
E. Resolve the childhood neurosis.

The correct response is option E (p. 1181; see Table 26–3). Psychoanalysis has as its primary goal the resolution of the childhood neurosis as it presents itself in the transference neurosis.

26.3 Which form of therapy has the primary goal of defense and transference analysis with limited reconstruction of the past?

A. Cognitive-behavioral psychotherapy.
B. Interpersonal psychotherapy.
C. Psychoanalysis.
D. Psychoanalytic psychotherapy.
E. Supportive psychotherapy.

The correct response is option D (p. 1185; see Table 26–7). The goal of psychoanalytic psychotherapy is defense and transference analysis with limited reconstruction of the past.

26.4 A goal of supportive psychotherapy is

A. Maintenance of function.
B. Resolution of unconscious conflict.
C. Restructuring of personality.
D. Reversal of pathology.
E. Understanding of symptoms.

The correct response is option A (p. 1190; see Table 26–11). Goals of supportive therapy are maintenance and restoration of function, coping with pathology, and alleviation of symptoms. In contrast, goals of psychoanalytic therapy are reversal of pathology, restructuring of personality, resolution of unconscious conflict, and understanding of symptoms.

26.5 A key therapist technique used in supportive psychotherapy is

A. Attention to process.
B. Confrontation.
C. Facilitation of fantasy.
D. Frustration of wishes.
E. Reinforcement of existing defenses.

The correct response is option E (p. 1193; see Table 26–15). In supportive therapy, the therapist attempts to strengthen the patient's defenses rather than scrutinizing and interpreting them. In contrast to the abstinent and neutral stance assumed in psychoanalytic therapy, the supportive therapist is active and spontaneous, more readily taking positions, answering questions, giving advice, and offering direction.

CHAPTER 27

Interpersonal Psychotherapy

Select the single best response for each question.

27.1 Which of the following statements is true about interpersonal psychotherapy (IPT)?

A. Focuses on any issue the patient brings up.
B. Takes an open-ended approach.
C. Has not been validated in controlled trials.
D. Is a long-term treatment.
E. Is based on the premise that depression is a medical illness and not the patient's fault.

The correct response is option E (p. 1207). IPT has two basic premises: first, that depression is a medical illness that is treatable and not the patient's fault; and second, that the disorder does not occur in a vacuum but rather is influenced by and itself affects the patient's psychosocial environment.

27.2 Interpersonal psychotherapy is based on the work of all of the following *except*

A. Aaron Beck.
B. Gerald Klerman.
C. John Bowlby.
D. Adolf Meyer.
E. Harry Stack Sullivan.

The correct response is option A (pp. 1207, 1208). IPT is a time-limited treatment that the late Gerald L. Klerman, M.D., and Myrna M. Weissman, Ph.D., developed in the 1970s for adult outpatients with major depression (Klerman et al. 1984; Weissman et al. 2000). IPT is based on interpersonal theory deriving from the post–World War II work of Adolf Meyer, Harry Stack Sullivan (1953), and, later, John Bowlby and others.

27.3 A significant difference between IPT and cognitive-behavioral therapy (CBT) is

A. IPT links reactions to events; CBT does not.
B. IPT focuses on affects.
C. IPT is less structured.
D. IPT is manualized; CBT is not.
E. IPT focuses on homework.

The correct response is option B (p. 1209; see Table 27–2). IPT and CBT are similar in that both are manualized, active, time limited, and structured; have a "here and now" focus; can be combined with antidepressant medication; have goals of self-assertion and mastery; and have as their ultimate objective the acquisition of new skills for prophylaxis. The two therapies differ in several ways. For example, IPT uses a medical model; CBT uses homework. Also, IPT focuses on affects, whereas CBT focuses on thoughts; as a result, CBT has a more external focus, in contrast to IPT's more intrapsychic approach.

27.4 Empirically based indications for IPT include all of the following *except*

A. Adolescent depression.
B. Geriatric depression.
C. HIV-positive depression.
D. Post–cerebrovascular accident (CVA) depression.
E. Postpartum depression.

The correct response is option D (p. 1212, Table 27–5). IPT has been found to be effective in the acute and maintenance treatment of major depression; in geriatric, adolescent, primary care, and HIV-positive populations with depression; in depressed women with marital conflicts; and in patients with antepartum/postpartum depression.

27.5 An 8-month trial of IPT versus amitriptyline versus placebo versus an IPT–amitriptyline combination versus an IPT–placebo combination for depression revealed that

A. Both amitriptyline and IPT prevented relapse.
B. IPT increased social functioning after 6–8 months.
C. IPT increased social functioning after 6–8 months and prevented relapse.
D. Combined IPT–amitriptyline did not prove better than either alone.
E. Amitriptyline was equal to placebo in preventing relapse.

The correct response is option B (p. 1213). In this initial trial of IPT (Klerman et al. 1974; Paykel et al. 1975; Weissman et al. 1974), maintenance pharmacotherapy was found to prevent relapse and symptom exacerbation, whereas IPT improved social functioning. The effects of IPT on social functioning did not appear for 6–8 months. The best outcomes were seen for combined psychotherapy–pharmacotherapy.

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CHAPTER 28

Behavior Therapies

Select the single best response for each question.

28.1 One of the basic principles underlying the contemporary conceptual basis for behavior therapy is that

A. Normal and abnormal behaviors are learned and maintained in different ways.
B. Changing the social environment will not help to maintain newly acquired behaviors and prevent relapse.
C. It is critical to elucidate the underlying conflict leading to behavior.
D. Controlled trials are no longer necessary for treatment validation.
E. Reinforcement is a source of information about the potential effects of future behavior.

The correct response is option E (p. 1225). Reinforcement is viewed not as the automatic effect of reward but rather as a source of information about the potential effects of future behavior.

28.2 Basic research is beginning to unravel the biology of learning. Which of the following is true?

A. Studies of *Aplysia* (sea mollusk) have revealed that permanent chemical changes occur in response to learning (e.g., avoidance behavior).
B. Patients successfully treated with behavior therapy in a study of obsessive-compulsive disorder (OCD) showed changes in glucose metabolism of the caudate nucleus as detected by positron emission tomography.
C. Behavior therapy and antidepressants change glucose metabolism in different ways with regard to OCD.
D. Environmental events influence biological processes but not vice versa.
E. Behavior therapy is efficacious for acute episodes but not for prophylaxis.

The correct response is option B (p. 1226). Rates of glucose metabolism in the right head of the caudate nucleus changed when the OCD was successfully treated but did not change in patients who did not respond to treatment (Baxter et al. 1992). Moreover, these changes were similar to those produced by antidepressant treatment.

28.3 A 22-year-old woman experiences a sudden panic attack while presenting a paper in her class. She subsequently has several further attacks (apparently precipitated by thoughts of failure), loses her appetite, and begins to lose weight. In addition, she begins to avoid leaving home unless accompanied by her husband. She is particularly afraid that her wealthy and successful husband will divorce her and find a more suitable companion. The primary treatment indicated for this patient is

A. Aversion therapy.
B. Cognitive therapy.
C. Positive reinforcement.
D. Relaxation training.
E. Systematic desensitization.

The correct response is option B (p. 1227). This patient has had frequent panic attacks, is exhibiting agoraphobia, and has some depressive symptoms (loss of appetite, weight loss). Because her panic attacks are related to her fear of failure and her fear that her husband will divorce her as a result of that failure, this patient is a particularly good candidate for cognitive therapy.

28.4 The behavioral treatment of choice for social phobia is

A. Biofeedback.
B. Exposure therapy and cognitive restructuring.
C. Positive reinforcement.
D. Relaxation training.
E. Systematic desensitization.

The correct response is option B (p. 1231). Findings of controlled studies suggest that the behavioral treatment of choice for social phobia is a combination of exposure therapy and cognitive restructuring. The addition of cognitive restructuring to exposure therapy may also prevent relapse. The principal area of focus for cognitive change is in eliciting the details of the socially phobic patient's fears of negative evaluation by others and challenging the reality of these ideas.

28.5 Behavior therapy for mild to moderate obesity includes all of the following *except*

A. Adherence to a high-fat, low-carbohydrate diet.
B. Narrowing the stimuli associated with eating.
C. Reinforcement of an increase in activity levels.
D. Self-monitoring.
E. Slowing of the eating rate.

The correct response is option A (p. 1235). Behavioral treatment for mild to moderate obesity contains the following elements: 1) self-monitoring; 2) reinforcement of an increase in activity levels; 3) slowing of the eating rate; 4) narrowing of the stimuli associated with eating; 5) adherence to a low-fat, high-fiber, heart-healthy diet; and 6) use of reinforcement and self-reinforcement to attain short-term goals.

Reference

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CHAPTER 29

Cognitive Therapy

Select the single best response for each question.

29.1 All of the following are true about the cognitive model for psychotherapy *except*

A. It is grounded in the theory that persons with certain psychiatric conditions exhibit characteristic errors in information processing.
B. Cognitive distortions lead to dysphoric affect.
C. Errors in logic lead to maladaptive behavior.
D. Misattribution leads to conflict.
E. The classic cognitive triad includes self, other, and the past.

The correct response is option E (p. 1246). The cognitive model for psychotherapy is grounded on the theory that characteristic errors in information processing are present in depression, anxiety disorders, personality disturbances, and other psychiatric conditions. For example, Beck (1976; Beck and Rush 1992) has proposed that individuals with depressive disorders have three major areas of cognitive distortion—the negative cognitive triad of self, world, and future—and that persons with anxiety disorders habitually overestimate the danger or risk in situations. Cognitive distortions such as misperceptions, errors in logic, and misattributions are thought to lead to dysphoric affect and maladaptive behavior.

29.2 Reviews of the extensive research on cognitive processes in depression have found strong evidence that

A. Depressed patients exhibit a negative cognitive bias.
B. Anxious patients have less propensity to recall past dangerous situations.
C. Depressive patients overestimate potentially dangerous stimuli.
D. Depressed individuals and nondepressed control subjects equally estimate the amount of positive feedback they receive.
E. Hopelessness for depressed patients does not predict suicidal outcome.

The correct response is option A (pp. 1249–1250). Reviews of the voluminous research on cognitive processes in depression have found strong evidence for a negative cognitive bias in this disorder. For example, distorted automatic thoughts and cognitive errors have been found to be much more frequent in depressed persons that in control subjects. A selective recall bias also has been described. Depressed individuals are more likely to remember negative than positive self-referent information.

29.3 A method for enhancing collaborative empiricism in the therapeutic relationship is

A. Focus on the positives rather than the negatives.
B. Focus on transference issues.
C. Maintain a hierarchical relationship with the patient.
D. Provide monitoring for the patient.
E. Provide and request feedback on a regular basis.

The correct response is option E (p. 1251; see Table 29–5). Techniques for enhancing collaborative empiricism include the following:

- Work together as an investigative team.
- Adjust therapist activity level to match the severity of illness and phase of treatment.
- Encourage self-monitoring and self-help.

- Obtain accurate assessment of validity of cognitions and efficacy of behavior.
- Develop coping strategies for real losses and actual deficits.
- Promote essential “nonspecific” therapist variables (e.g., kindness, empathy, equanimity, positive general attitude).
- Provide and request feedback on a regular basis.
- Recognize and manage transference.
- Customize therapy interventions.
- Use gentle humor.

29.4 Mr. G, a 48-year-old man with depression, told his therapist, “I don’t enjoy anything anymore.” He stated that working at home was horrible. In reviewing recent events, however, he reported enjoying reading while sitting alone and spending time with his son. The cognitive intervention primarily indicated is

A. Activity scheduling with mastery and pleasure recording.
B. Decatastrophizing.
C. Generating alternatives.
D. Self-monitoring.
E. Thought recording.

The correct response is option A (p. 1260). The patient’s depressive symptoms appear to be related to problems working at home. Because he derives pleasure from some activities (reading alone, spending time with his son), activity scheduling with mastery and pleasure recording is the preferred cognitive intervention. Discussion of the activity scheduling assignment with Mr. G helped him to see that he was still capable of performing reasonably well in certain areas and also that he was able to derive considerable enjoyment from some activities. In addition, the schedule was used to target problem areas (e.g., working in his home office) that would require further work in therapy.

29.5 There is a growing interest in research of cognitive therapy and related therapies for psychotic disorders. Findings from research include all of the following *except*

A. Better efficacy for cognitive therapy than for supportive therapy in reduction of positive symptoms.
B. Fewer residual symptoms in patients treated with cognitive therapy.
C. Reduced time required for recovery with cognitive therapy.
D. Substantial improvement in negative symptoms with cognitive therapy.
E. Substantial improvement in positive symptoms with cognitive therapy.

The correct response is option D (p. 1271). Several randomized controlled investigations of cognitive therapy for psychosis have been conducted since 1996. Drury et al. (1996a, 1996b) found substantial improvement in positive symptoms and reduced time required for recovery in a group of inpatients treated with cognitive therapy.

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CHAPTER 30

Hypnosis

Select the single best response for each question.

30.1 Many mistaken beliefs are held about hypnosis. Which of the following is true?

A. Hypnosis can be dangerous.
B. Hypnosis induces a state like sleep.
C. Hypnosis is intrinsically therapeutic.
D. Hypnotizability is a marker of psychological susceptibility.
E. Hypnotizability is a trait; not everyone is hypnotizable.

The correct response is option E (p. 1287; see Table 30–1). A variety of "mythunderstandings" about hypnosis exist; corrections to some of the most prevalent of these follow:

- Hypnosis is not sleep.
- Hypnotizability is a trait: not everyone is hypnotizable.
- Hypnosis is not something *done to* a subject or a patient.
- Hypnotizability is *not* a susceptibility or a sign of weak-mindedness.
- There is nothing intrinsically dangerous about hypnosis.
- There is nothing intrinsically therapeutic about hypnosis.

30.2 Which of the following statements is true about hypnosis and/or hypnotizability?

A. A patients' ability to be hypnotized predicts a positive outcome with acupuncture if used with hypnosis.
B. An inability to be hypnotized predicts a positive outcome for anxiety disorder patients.
C. Patients show heightened concentration and increased receptiveness during hypnosis.
D. Sensory deprivation reduces hypnotizability.
E. Use of psychotomimetic drugs reduces hypnotizability.

The correct response is option C (pp. 1289–1290). Because hypnotic trance involves an intensification of concentration and an increase in receptiveness, it would make sense that the capacity to experience hypnosis should be correlated with responsiveness to treatment.

30.3 All of the following disorders are associated with increased hypnotizability (in comparison with control subjects) *except*

A. Fugue.
B. Dissociative identity disorder.
C. Dissociative amnesia.
D. Schizophrenia.
E. Posttraumatic stress disorder.

The correct response is option D (p. 1290). Clinicians have long observed that it is unusual to find a patient with a severe dissociative disorder—such as fugue, amnesia, or dissociative identity disorder—who is not highly hypnotizable. Moreover, in two studies, hypnotizability in combat veterans with posttraumatic stress disorder was found to be significantly higher in comparison with that in other patient groups and control subjects (Spiegel et al. 1988; Stutman and Bliss 1985).

30.4 Hypnosis is being applied to various respiratory and pulmonary conditions. Which of the following is true?

A. Hypnosis may help asthmatic patients use less drugs as an attack begins.

B. A study by Collison (1975) showed that 50% of asthmatic patients had “complete symptom resolution” after hypnotic treatment and training.

C. A study of patients using hypnosis for cystic fibrosis (Anbar 2000) reported worsening of symptoms in 25% of cases.

D. Hypnosis was not useful for psychogenic dyspnea in children, because they could not learn to do it (Anbar 2001).

E. Hypnosis was not helpful for patients being weaned from ventilators in the intensive care setting (Jacavone and Young 1998).

The correct response is option A (p. 1310). Asthma patients can learn to use self-hypnotic techniques rather than medication when they begin to feel an anxiety-precipitated asthmatic attack coming on. Collison (1975) found that one-fifth of his asthma patients experienced “complete symptom resolution” and that one-third had “considerable improvement in symptoms” after hypnotic treatment and training. Anbar (2000) reported on the utility of teaching self-hypnosis to patients with cystic fibrosis; patients using these techniques achieved symptom control 86% of the time. Self-hypnosis training was also found to be helpful for children with psychogenic dyspnea (Anbar 2001). Jacavone and Young (1998) reported on the use of hypnosis, guided imagery, and biofeedback to help “difficult-to-wean” patients discontinue use of ventilators in the critical care setting.

30.5 A major criticism regarding the use of hypnosis in forensic or legal cases is that

A. Hypnosis does not help the witness to recall important information in most cases.

B. Confabulation of material by the witness occurs to please the hypnotist.

C. Hypnosis often muddies testifying by a witness, because information before and after hypnosis often does not match.

D. Hypnosis is used too often in the courtroom while the witness is testifying.

E. A witness makes confident errors, which are defined as errors due to too much confidence in one’s testimony, because memory is more accurate after hypnosis.

The correct response is option B (p. 1319). There has been serious criticism of the use of hypnosis with witnesses and victims. One of the charges leveled at the technique is that it can lead to *confabulation*—that is, a hypnotized witness will make up material and become what has been called an “honest liar”—someone who believes his or her misstatement out of a desire to please the hypnotist or simply as a result of being in the nonrational hypnotic state itself.

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CHAPTER 31

Group Therapy

Select the single best response for each question.

31.1 A prototypical interactionally oriented group uses which of the following major therapeutic factors or techniques?

A. Building cohesiveness.
B. Corrective recapitulation of primary family group.
C. Demonstration of imitative behavior.
D. Discussion of existential factors.
E. Instillation of hope.

The correct response is option B (p. 1336; see Table 31–1). Prototypical interactionally oriented groups use interpersonal learning and corrective recapitulation of the primary family group.

31.2 A 30-year-old woman is diagnosed with schizoaffective disorder and borderline diabetes mellitus during psychiatric hospitalization. She does not relate well to others and has few friends. She participated in an aftercare group for 1 month after her discharge from the hospital, and it helped her learn about her illness. Which type of group would be best for this patient at this point?

A. Interactionally oriented group.
B. Medication or clinic group.
C. Behaviorally oriented group.
D. Specialized group for medical disorders.
E. Specialized group for life events.

The correct response is option B (p. 1336; see Table 31–1). A medication or clinic group would be the best choice for this patient. Through use of universality, imparting of information, socializing techniques, and altruism, these groups provide support, education, and help in maintaining function. They are appropriate for patients on long-term psychiatric medication who are able to tolerate the group setting. Patients with schizoaffective disorder, a chronic illness requiring long-term treatment, often do not relate well socially. Because this patient previously responded well to an aftercare group, a medication or clinic group should be helpful for her.

31.3 The use of a co-therapist for a group may be problematic because

A. A difference in the gender of the therapists causes tension for patients.
B. A wide array of transference issues are less likely to manifest when there are two therapists.
C. In training situations, an inexperienced therapist makes too many mistakes despite being paired with an experienced therapist.
D. Patients will differ in their reactions to each of the co-therapists.
E. A co-therapist has to defend the other therapist against attacks by patients.

The correct response is option D (pp. 1346–1347). The co-therapy format provides the group with a wider array of transferential possibilities, because patients will differ in their reactions to each of the co-therapists and to the co-therapists' relationship.

31.4 Rationales supporting the practice of preparing patients for group therapy include all of the following *except*

A. Reduce expectations about the effects of the group.
B. Establish a treatment contract.

C. Provide a rational explanation of the group therapy process.
D. Describe the behavior expected of patients toward others in the group.
E. Predict some of the common problems that might occur in the group.

The correct response is option A (pp. 1349–1350). A cognitive approach to group therapy preparation has several goals:

- Provide a rational explanation to the patient about the group therapy process.
- Describe the behavior expected of patients toward the group.
- Establish a treatment contract.
- Raise expectations about the effects of the group.
- Predict some of the common problems and discouragement that may be encountered in early meetings.

31.5 Conflict between patients in a medication or clinic group should be

A. Vigorously controlled by the therapist to keep it within constructive bounds.
B. Discussed thoroughly to get at childhood conflicts and existential issues.
C. Openly encouraged so that patients get a chance to vent.
D. Facilitated to generate cohesiveness.
E. Halted only if yelling and other significant disturbance starts to occur.

The correct response is option A (p. 1352). Therapists should remember that conflict can easily get out of hand, no matter what the group setting. Leaders will often have to intervene vigorously to keep conflict within constructive bounds.

CHAPTER 32

Couple and Family Therapy

Select the single best response for each question.

32.1 Studies of couple and family therapy for psychiatric disorders have revealed that it

A. Is more effective than individual therapy in engaging patients with alcoholism in treatment.
B. Is effective in educating caregivers of patients with dementia but does not reduce caregiver burden or depression.
C. Is not effective for bipolar disorder.
D. Is not effective in the aftercare of patients with alcoholism.
E. Is not effective in engaging patients with drug abuse in treatment.

The correct response is option A (p. 1375). For alcoholism, there is good scientific evidence that couple and family therapy is more effective than individual treatment in engaging patients in treatment.

32.2 Which of the following is true regarding couple and family therapy?

A. Intensive uncovering couple therapy was found to be contraindicated for married women with unipolar depression on an inpatient unit.
B. Couple therapy is not indicated for psychosexual problems.
C. Family therapy is not efficacious for adolescent patients with conduct disorder.
D. Family therapy is not indicated for childhood oppositional defiant disorder.
E. Family therapy is contraindicated for adolescents with drug abuse.

The correct response is option A (pp. 1375–1376). Although couple therapy has been shown to be superior to individual therapy for "unipolar depressed outpatient women in distressed marriages" (Pinsof and Wynne 1995, p. 603), studies conducted to date suggest that intensive uncovering couple therapy is contraindicated for married unipolar depressed *inpatient* women (Clarkin et al. 1990).

32.3 Conjoint assessment sessions are more valuable than individual sessions in couple and family therapy for

A. Facilitating emotional disclosures.
B. Facilitating disclosure of dangerous behavior (e.g., violence).
C. Giving patients a chance to vent.
D. Identifying individual issues.
E. Observing patterns of interaction.

The correct response is option E (pp. 1377–1378). Conjoint assessment sessions are invaluable for observing family interaction patterns.

32.4 A couple married after the woman unexpectedly became pregnant. Although they reported having loved one another prior to the pregnancy, they admitted being unsure whether they would have gotten married if the pregnancy had not occurred. Once the child was born and was raised to age 7, the alliance between the father and daughter became problematic for the mother. The best intervention, according to a systems theory–based approach, is to

A. Guide the family to reward desired behaviors.
B. Teach communication, negotiation, and problem solving.
C. Focus attention and action on shifting interactional patterns.

D. Employ observation, clarification, and interpretation.
E. Create experiences in which family members can express their emotions.

The correct response is option C (p. 1381; see Table 32–3). In this example, the principal therapeutic focus is related to interactional problems between the father and daughter, in part as a result of the parents' need to marry because of the unexpected pregnancy. A systems theory–based approach would focus attention and action on altering the existing interactional patterns. Dysfunction is viewed as a current structural imbalance in the family (e.g., weak parental alliance). The goal of therapy is to reorganize the family structure by shifting members' relative positions to one another to disrupt the malfunctioning pattern and strengthen the parental hierarchy. The therapist should assume a pragmatic, focused, action-oriented stance to facilitate the shifting of interaction patterns.

32.5 Which of the following is true regarding the treatment of culturally and structurally diverse families? The therapist should

A. Focus primarily on the cultural aspects of the problems presented.
B. Learn about typical cultural patterns of behavior, because such patterns will be present in every family.
C. Evaluate varying levels of acculturation in family members.
D. Not show too much interest in the family's culture, because doing so will alienate them.
E. Encourage families to change their views to fit with the culture within which they currently live.

The correct response is option C (p. 1393; see Table 32–4). The following guidelines are particularly important for therapists who treat culturally and structurally diverse families:

- Assess level of acculturation in immigrant families to understand how much family members' backgrounds will inform clinical decisions. Differing levels of acculturation in immigrant families are often great sources of conflict when some members start to behave according to mainstream values.
- Acknowledge—show interest in, demonstrate knowledge of, and express appreciation for—the family's culture. Place their problems in a cultural context.
- Obtain information about the culture of the family as well as culture-specific interventions.
- Be careful not to overgeneralize cultural patterns to all members of a particular group; the "culture of the family" may be quite different.

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CHAPTER 33

Treatment of Children and Adolescents

Select the single best response for each question.

33.1 There are developmental differences in drug distribution in children as compared with adults. The primary reason for increased dosing in children is

A. Higher proportional intracellular water volume.
B. Faster metabolic rate.
C. Higher proportional body fat.
D. Pharmacodynamics.
E. Pharmacogenetics.

The correct response is option B (p. 1402). This greater metabolic rate has been postulated as the principal factor contributing to lower drug plasma concentration levels and shorter drug half-lives in children compared with adults.

33.2 The primary issue predicting adherence to medication regimens in children is

A. Age.
B. Attitudes about medication.
C. Ethnicity.
D. Gender.
E. Knowledge of medication.

The correct response is option B (p. 1403). In a group of inpatient adolescents, compliance correlated better with attitudes than with knowledge of pharmacotherapy, indicating a need to examine and explore a child's feelings about taking medications (Bastiaens 1995).

33.3 A 8-year-old boy is highly aroused, hyperactive, impulsive, and labile. On examination, he is found to have motor tics. The medication most likely to treat all of these symptoms is

A. Clonidine.
B. Methylphenidate.
C. Risperidone.
D. A selective serotonin reuptake inhibitor.
E. A tricyclic antidepressant.

The correct response is option A (p. 1410). Clonidine is useful in modulating mood and activity level and in improving cooperation and frustration tolerance in a subgroup of children with attention-deficit/hyperactivity disorder (ADHD), especially those who are highly aroused, hyperactive, impulsive, defiant, and labile. Steingard et al. (1993) reported that children with ADHD and comorbid tics may have a more positive response to clonidine than do children with ADHD without tics.

33.4 Which mood stabilizer is approved by the U.S. Food and Drug Administration for bipolar patients age 12 years and older?

A. Carbamazepine.
B. Lithium.
C. Oxcarbazepine.
D. Topiramate.
E. Valproate.

The correct response is option B (p. 1417). Lithium, an element with antimanic properties, has been approved since 1970 in the United States for the treatment of mania in bipolar patients 12 years of age and older.

33.5 A 12-year-old youth presents to the emergency room with aggressive behavior toward his father (e.g., yelling, throwing objects), having been found after running away from a group home. His history is also significant for truancy and periodic use of amphetamines, although his current toxicology screen is negative. There is a history of alcohol abuse but no known dependence or withdrawal symptoms. The youth is not interested in treatment. Which of the following treatments/settings should this patient receive?

A. Individual outpatient care.
B. Family therapy in the outpatient setting.
C. Residential treatment.
D. Short-term inpatient hospitalization.
E. Long-term inpatient hospitalization.

The correct response is option C (p. 1436). Placement in a residential treatment center may be indicated for children and adolescents with chronic behavior problems such as aggression, running away, truancy, substance abuse, school phobia, or self-destructive acts that the family, foster home, and/or community cannot manage or tolerate.

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CHAPTER 34

Suicide

Select the single best response for each question.

34.1 The current U.S. suicide rate (annual) is

A. 5–10 per 100,000.
B. 10–15 per 100,000.
C. 15–20 per 100,000.
D. 20–25 per 100,000.
E. 25–30 per 100,000.

The correct response is option B (p. 1457). Despite the development of suicide prevention programs, greater recognition of depression, and advances in biological treatments for depression, the overall rate of suicide has not changed over the past several decades; it has remained in the range of 11–12 per 100,000 annually.

34.2 The suicide *completion* rate is increased by all of the following *except*

A. Access to firearms.
B. Specific occupations (e.g., medicine, law enforcement).
C. Unemployment.
D. Increased age.
E. Female sex.

The correct response is option E (p. 1458). The availability of firearms also appears to correlate with suicide risk. In a study involving five New York counties, Marzuk et al. (1992) demonstrated that the differences in overall suicide risk among counties were explained by differentially available lethal means of injury. Boxer et al. (1997) reviewed the literature on occupation and suicide and concluded that chemistry, farming, law enforcement, and medicine appeared to confer a high risk for suicide and that the risk for female physicians may be particularly high. Unemployment has also been shown to increase the rate of suicide for both men and women. Most strikingly, the high rate of completed suicides in Caucasian males initially peaks between ages 20 and 40 years, levels off between ages 40 and 65 years, and then rapidly increases after age 65 years, becoming extraordinary at age 85 and older (i.e., 50 suicides per 100,000). The male:female ratio of suicides in the United States increased from 3.1:1 in 1972 to 4.2:1 in 1990.

34.3 The risk for suicide *attempts* is increased by all of the following *except*

A. Female sex.
B. Age over 35 years.
C. Low-lethality means.
D. High chance of rescue.
E. Adjustment and personality disorders.

The correct response is option B (p. 1459; see Table 34–2). Suicide attempters are more likely to be young (less than age 35 years) and female, to have an adjustment or personality disorder, to use a low-lethality method (e.g., wrist laceration), and to select a setting with a high chance of rescue (e.g., home). Suicide completers, by contrast, are more likely to be older (over age 60 years) and male, to have a mood or substance abuse disorder, to use a high-lethality method (e.g., firearms, hanging), and to select an isolated setting with a low chance of rescue.

34.4 All of the following nations have a high rate of suicide *except*

A. Germany.
B. Hungary.
C. Sweden.
D. Japan.
E. Poland.

The correct response is option E (p. 1459). The highest suicide rates are in Germany, Scandinavia, Eastern Europe, and Japan, whereas the lowest rates are in the traditionally Catholic countries (i.e., Italy, Spain, and Ireland). Sartorius (1995) examined suicide rates in 15 European nations and found suicide rates in 1991 or 1992 to vary from a high of 38.7 per 100,000 annually in Hungary to a low of 14.9 per 100,000 annually in Poland.

34.5 Regarding the suicide risk associated with specific psychiatric illnesses, all of the following statements are true *except*

A. Suicide risk increases with most major psychiatric illnesses.
B. Nonpsychiatric patients with terminal illnesses account for 25% of suicides.
C. The vast majority of suicides are in people who were psychiatrically ill at death.
D. Most presuicide mental illnesses were probably treatable.
E. The risk of suicide in patients with mood disorders is likely between 15% and 20%.

The correct response is option B (pp. 1459–1460). In addition to elucidating the role of social factors in suicide, epidemiological surveys have demonstrated that the vast majority of completed suicides are in patients with diagnosable psychiatric conditions. There is also a higher incidence of suicides in nonpsychiatric patients with terminal illness (e.g., cancer), but even suicide in those with terminal illness accounts for only about 5% of the total number of suicides.

In a large meta-analysis, Harris and Barraclough (1997) examined 249 studies of psychiatric disorders and suicide risk with minimum 2-year follow-up. They found that 36 of the 44 psychiatric disorders studied showed an increased risk of suicide. Notably, only mental retardation and dementia did not exhibit an increased suicide risk.

Studies show that between 45% and 77% of persons who commit suicide have a mood disorder. In summary, about 15%–20% of patients with a mood disorder will commit suicide, making these disorders among the most lethal of medical conditions.

34.6 Characteristics of substance abusers who commit suicide include all of the following *except*

A. Ages 40–60 years.
B. Male.
C. Concurrent use of alcohol and multiple substances.
D. Recent interpersonal loss.
E. Comorbid borderline personality disorder.

The correct response is option A (p. 1461; see Table 34–3). According to Marzuk and Mann (1988), chemically dependent persons who complete suicide tend to be young males who use alcohol and other drugs concurrently, who have a history of overdoses, and who have comorbid psychiatric disorders, especially depressive disorders. Suicide in these individuals is likely to occur abruptly, often within 6 weeks of an interpersonal loss.

34.7 Regarding serotonin and serotonin metabolites (e.g., 5-hydroxyindoleacetic acid [5-HIAA]) in suicide completers, which of the following statements is true?

A. Serotonin and 5-HIAA are increased in the brain stem.
B. Serotonin and 5-HIAA levels are decreased in the cortex.
C. Platelet imipramine binding has been used as a marker of postsynaptic serotonergic function.
D. Suicide completers show increased imipramine binding in the cortex and hypothalamus.
E. Studies using ligand binding have shown that postsynaptic serotonin receptor binding is increased in the frontal and prefrontal cortices of suicide completers.

The correct response is option E (pp. 1468–1470). Through use of ligands such as ^{3}H-labeled spiroperidol, ^{3}H-labeled ketanserin, or ^{125}I-labeled LSD, it is possible to measure postsynaptic serotonin binding sites. Several studies have noted an increase in serotonin-2 (5-HT$_2$) receptor binding in the frontal and prefrontal cortices of suicide completers; this is thought to represent a compensatory upregulation of receptors after reduced serotonin neuronal activity.

34.8 Regarding somatic treatments and suicide, all of the following statements are true *except*

A. Preliminary studies suggest that selective serotonin reuptake inhibitors (SSRIs) may be effective in suicidal patients with disorders other than major depression.
B. Their neurotransmitter effects make SSRIs the definitive choice for suicidal, depressed patients.
C. SSRIs and other newer-generation antidepressants (rather than tricyclic antidepressants [TCAs]) should be used in suicidal patients because of their greater safety in overdose.
D. Lithium reduces the risk of suicide in bipolar affective disorder.
E. Electroconvulsive therapy (ECT) may be considered for prompt onset of antidepressant effects in the suicidal depressed patient.

The correct response is option B (pp. 1475–1476). Interestingly, some studies suggest that serotonergic agents may selectively decrease suicidality and impulsiveness not only in patients with major depressive disorder (Muijen et al. 1988) but also in patients with borderline personality disorder (Cornelius et al. 1991; Norden 1989). One study compared the relative effectiveness of serotonergic antidepressants with that of noradrenergic antidepressants in the treatment of patients with major depressive disorders who had already made suicide attempts; the serotonergic antidepressants were found to be significantly more effective in the treatment of these patients (Sacchetti et al. 1991). A more recent study demonstrated a significant reduction in suicidal behavior with the SSRI paroxetine in a heterogeneous group of patients who had recurrent suicidal behavior but did not have major depression at the time of the study (Verkes et al. 1998). This is an intriguing finding in light of the posited serotonergic hypofunction in suicidal patients. However, literature to date is too preliminary to support the hypothesis that SSRIs are the antidepressants of choice in the suicidal patient because of their neurotransmitter action. Rather, SSRIs and other new-generation antidepressants may be viewed as more prudent choices than TCAs because of their low lethality index.

It is important to stress that maintenance pharmacotherapy is essential to the reduction of suicide risk in patients with mood disorders. Recent studies have shown that suicide risk is enhanced in bipolar patients when lithium is discontinued and is markedly reduced when patients with bipolar disorder maintain their lithium regimens (Baldessarini 1999a, 1999b; Tondo et al. 2001).

Finally, the role of ECT cannot be overemphasized as a safe and relatively rapid somatic treatment for the acutely suicidal depressed patient.

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CHAPTER 35

Violence

Select the single best response for each question.

35.1 Risk factors for violent behavior include all of the following *except*

A. Being a victim of child abuse.
B. Environments with increased social control.
C. Increased social strain.
D. Access to firearms.
E. Extremely hot ambient temperatures in the environment.

The correct response is option E (pp. 1486–1487). Kempe and Helfer (1980) found childhood abuse to be related to becoming physically abusive as an adult. In fact, even witnessing intrafamily violence, such as spouse abuse, is related to increased problems with violence among children.

Another risk factor for violent behavior is increased social strain. *Social strain* refers to negative emotions that are induced when structural conditions make it difficult for people to realize cultural goals and expectations through legitimate means.

Access to firearms also increases the risk for violent behavior. Evidence has shown that the number of homicides associated with firearms has risen significantly in the past century, particularly since 1960. Firearms are important because they can turn what would have been an assault into a homicide.

Finally, with regard to the effect of temperature on the risk for violence, Bell and Baron (1981), after reviewing several ecological and ethological studies as well as laboratory studies, concluded that moderately uncomfortable ambient temperatures produce an increase in aggression, whereas extremely hot temperatures decrease aggression.

35.2 Psychiatric illnesses associated with increased risk of violent behavior include all of the following *except*

A. Schizophrenia, especially if paranoid delusions are present.
B. Delusional disorder, paranoid and jealous types.
C. Bipolar disorder, depressed episode.
D. Antisocial, borderline, and paranoid personality disorders.
E. Intermittent explosive disorder.

The correct response is option C (pp. 1488–1489). Schizophrenia is the most frequent diagnosis found in patients with psychosis and violence. Delusional disorder can be associated with violent behavior, especially the paranoid and jealous types. Violence by patients with bipolar I disorder frequently occurs during the acute phase of a manic episode. Some personality disorders, namely the antisocial and borderline types, increase the risk of violence. Patients with paranoid personality disorder frequently threaten violence, because they often feel persecuted and/or discriminated against as a result of race, gender, or some other personal attribute. Intermittent explosive disorder is characterized by discrete episodes of loss of control resulting in serious violence toward persons or destruction of property.

35.3 Substances of abuse that are associated with violent behavior include all of the following *except*

A. Alcohol.
B. Cocaine.
C. Phencyclidine.
D. Ecstasy.
E. Cannabis.

The correct response is option E (p. 1489). Alcohol has been found to increase the risk of violence. Cocaine produces violent behavior, usually during severe intoxication and/or delirium. Phencyclidine intoxication is manifested by belligerence, assaultiveness, ataxia, dysarthria, muscle rigidity, seizures, and hyperacusis. Ecstasy has amphetamine and hallucinogenic properties; it produces confusion, severe anxiety, paranoia, depression, and aggression.

35.4 Central nervous system (CNS) illnesses associated with an increased risk of violence include all of the following *except*

A. Traumatic brain injury.
B. HIV disease.
C. Tumors.
D. Seizure disorder.
E. Parkinson's disease.

The correct response is option E (p. 1490). Organicity increases the risk of violence. CNS disorders associated with violent behavior include traumatic brain injury, HIV infection, and other intracranial infections (encephalitis, postencephalitic syndrome); tumors; seizures (especially postictally); cerebrovascular disorder; Huntington's disease; Alzheimer's disease; Wilson's disease; multiple sclerosis; and normal-pressure hydrocephalus.

35.5 Guidelines for management of seclusion and restraint include all of the following *except*

A. MD sees patient within 1 hour of initiation of restraint.
B. MD sees patient every 4 hours while patient is restrained.
C. RN observes patient every hour while patient is restrained.
D. RN visits patient every 2 hours while patient is restrained.
E. With 4-point restraints, each limb restraint should be loosened or removed every 15 minutes.

The correct response is option C (pp. 1491–1492; see Table 35–4). Use of seclusion and restraint entails a responsibility to provide adequate monitoring, care, and attention. The following guidelines apply to mental health staff:

- Physician sees patient within 1 hour after beginning of the seclusion or restraint.
- Physician sees patient in seclusion or restraint every 4 hours and writes another order.
- Nursing staff should observe patient at least every 15 minutes.
- Nursing staff should visit patient at least every 2 hours.
- With four-point restraints, each limb should be released or restraint loosened every 15 minutes.

35.6 For the long-term pharmacological management of violent behavior, all of the following medication classes are recommended *except*

A. Atypical antipsychotics.
B. Lithium.
C. Anticonvulsants.
D. Beta-blockers.
E. Short-acting benzodiazepines.

The correct response is option E (pp. 1498–1501). The use of standard anxiolytic drugs such as diazepam or lorazepam for the control of violence over a long period of time is generally not recommended.

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CHAPTER 36

Women's Mental Health

Select the single best response for each question.

36.1 Estrogen exerts psychoactive effects through its modulation of neurotransmitters and drug metabolism. Which of the following statements is true about estrogen?

A. It has antiserotonergic effects.
B. It has dopaminergic effects.
C. It increases levels of some tricyclic antidepressants.
D. It increases levels of some benzodiazepines.
E. It worsens mood.

The correct response is option C (p. 1511). Estrogen has an inhibitory effect on oxidative hepatic metabolism, thus potentially increasing blood levels of drugs that are oxidatively metabolized (e.g., many tricyclic antidepressants, diazepam, clonazepam, chlordiazepoxide).

36.2 A 38-year-old woman reports bloating, breast tenderness, cramping, headaches, depression, and irritability. All of the following medical disorders are part of the differential diagnosis *except*

A. Nicotine dependence.
B. Cannabis abuse.
C. Endometriosis.
D. Fibrocystic breast disease.
E. Migraine headaches.

The correct response is option B (p. 1512). Medical evaluation should rule out physical conditions that may cause symptoms in association with the premenstrual phase of the menstrual cycle (e.g., endometriosis, fibrocystic breast disease, migraine headaches). Family psychiatric history, particularly any history of premenstrual symptoms and effective treatments in female relatives, is useful to guide treatment in the patient with premenstrual dysphoric disorder (PMDD). Medication use, including over-the-counter medications, should be recorded, and substances that may produce psychiatric side effects should be noted. The use of caffeine, salt, alcohol, and nicotine should be assessed because these may cause symptoms that mimic those of PMDD (e.g., bloating, lethargy, breast tenderness).

36.3 Oral contraceptives cause many systemic and psychiatric symptoms. Which of the following statements is true?

A. Estrogen causes weight gain.
B. Estrogen causes decreased libido.
C. Progesterone causes irregular bleeding.
D. Progesterone causes breast tenderness.
E. Progesterone causes elevated blood pressure.

The correct response is option C (p. 1513). Oral contraceptive agents also can be categorized according to their levels of estrogenic, progestational, and androgenic activities. Estrogenic side effects include nausea, breast tenderness, headaches, elevated blood pressure, and uterine fibroid enlargement. Side effects of progestational agents are weight gain, diminished libido, headaches, and irregular bleeding. Androgen-associated side effects include hirsutism, acne, and weight gain. However, the use of oral contraceptives may precipitate a recurrence in women with a history of depression or premenstrual dysphoria.

36.4 For which antidepressant are the most data available on its safe use during pregnancy?

A. Citalopram.
B. Fluoxetine.
C. Mirtazapine.
D. Duloxetine.
E. Nortriptyline.

The correct response is option B (p. 1516). To date, the most extensive information on the prenatal use of antidepressants involves fluoxetine. Prospective studies have not found an association between the use of fluoxetine during pregnancy and major congenital anomalies in the neonate.

36.5 It is estimated that up to 4 million women are assaulted by an intimate partner each year in the United States. For pregnant women, the most common part of the body on which they are beaten is

A. Head.
B. Chest.
C. Back.
D. Abdomen.
E. Extremities.

The correct response is option D (p. 1524). The rate of assaults to women by present or former partners is higher than that by all other assailants combined. About 7% of pregnant women are victims of domestic violence, and pregnant women who are abused tend to be beaten on the abdomen, in contrast with nonpregnant women, who tend to be struck in the face.

CHAPTER 37

Geriatric Psychiatry

Select the single best response for each question.

37.1 Common geriatric psychiatric syndromes include all of the following *except*

A. Acute confusion/delirium.
B. Insomnia.
C. Suspiciousness.
D. Somatization disorder.
E. Memory impairment.

The correct response is option D (p. 1535). Psychiatric syndromes common in geriatric populations include acute confusion, insomnia, suspiciousness, hypochondriasis, memory loss, anxiety, and depression.

37.2 Regarding insomnia in elderly patients, which of the following is *not* true?

A. Insomnia is more frequent in the elderly than in any other age group.
B. Nearly 50% of elderly patients report difficulty with falling asleep and staying asleep.
C. Primary insomnia is relatively rare; most sleep complaints are referable to systemic illnesses.
D. Sleep apnea is common.
E. Sleep–wake schedule disorder is frequent.

The correct response is option C (pp. 1539–1540). Insomnia is more frequent in the elderly population than in any other age group; 28% report difficulty falling asleep, and 46% report symptoms of difficulty in both falling asleep and staying asleep and use of more sedative-hypnotic medications. The most common sleep disturbances leading to insomnia in the elderly are 1) primary insomnia, which is a persistent difficulty in initiating and maintaining sleep that is not related to another mental disorder or known organic factor; 2) sleep-disordered breathing (i.e., sleep apnea); 3) nocturnal myoclonus, or periodic leg movements that disturb sleep; 4) sleep–wake schedule disorder, defined as a mismatch between the normal sleep–wake schedule for the elderly person's environment and his or her sleep–wake pattern.

37.3 Regarding anxiety disorders in the elderly

A. Agoraphobia and social phobia are more common than in younger patients.
B. Generalized anxiety disorder (GAD) is a frequent diagnosis.
C. Panic disorder is more common than GAD.
D. Posttraumatic stress disorder (PTSD) is found more frequently in older persons than in younger ones.
E. Severe manifestations of obsessive-compulsive disorder are more likely to be observed in older persons.

The correct response is option B (p. 1541). Although phobic disorders can affect persons at all stages of the life cycle, the more severe phobias, such as agoraphobia and social phobia, begin early in life and are more common in children and young adults than in older persons. Generalized anxiety disorder is a frequent diagnosis regardless of age, yet generalized anxiety is often comorbid with other psychiatric disorders such as major depression. Panic disorder is relatively frequent and severe among younger persons but much less so among older persons. Posttraumatic stress disorder can occur at any age but is found more frequently in younger persons than older persons. Obsessive-compulsive traits are common throughout the life cycle, although the severe manifestations of this disorder are less likely to be observed in older persons. Therefore, the management of anxiety symptoms in older persons usually consists of managing the symptoms of generalized anxiety that are the primary problem or comorbid with other disorders.

37.4 Regarding suspiciousness in the elderly, all of the following are true *except*

A. Persecutory and somatic delusions are the most common.
B. Suspiciousness and paranoid behavior were found in more than 15% of elderly individuals in one community survey.
C. A common reason for psychiatric referral in an elderly patient is dementia with suspicious, agitated behavior.
D. A family history of delusional disorder is common.
E. Sensory deprivation may be a potential risk factor.

The correct response is option D (pp. 1543–1544). The predominant delusions encountered in older persons are persecutory delusions and somatic delusions. Suspiciousness and paranoid behavior were found in 17% of persons in one community survey (Lowenthal 1964), and a sense of persecution was reported for 4% in another survey (Christenson and Blazer 1984). Thus, the perception by older persons that they live in a hostile social environment is common and represents a much larger proportion of older individuals than those who would be diagnosed as having schizophrenia or even suspiciousness secondary to cognitive impairment. Perhaps the most common encounter psychiatrists have with suspicious older persons is with demented patients who have become a management problem because of suspiciousness and agitation. A family history of suspiciousness and delusional thought is uncommon among suspicious older persons; thus, hereditary contributions are probably less important in later life than at earlier stages of the life cycle. Sensory deprivation also has been identified as a potential risk factor for suspiciousness, regardless of the underlying disorder. Social isolation likewise may contribute to suspiciousness.

37.5 Regarding depression in the elderly

A. Weight loss is infrequent.
B. The patient is more likely to report guilt and feeling worthless.
C. Elderly patients with depression are far more likely than middle-aged depressed patients to complain of cognitive symptoms.
D. Anhedonia is rare.
E. Psychotic symptoms are more likely than in younger patients.

The correct response is option E (pp. 1545–1546). Depressed mood is usually apparent in the older adult but may not be a spontaneous complaint. Older persons are more likely to experience weight loss (as opposed to weight gain or no change in weight) during a major depressive episode and are less likely to report feelings of worthlessness or guilt. Although older persons have more difficulty with cognitive performance tests during a depressive episode, they are no more likely than persons in midlife to report cognitive problems subjectively. Complaints of cognitive dysfunction are common in more severe depressive episodes, regardless of the person's age. Persistent anhedonia associated with a lack of response to pleasurable stimuli is a common and central symptom of late-life depression. Older persons are also more likely than younger persons to exhibit psychotic symptoms during a depressive episode.

37.6 Regarding hypochondriasis in the elderly, all of the following are true *except*

A. Symptoms described often are gastrointestinal or genitourinary.
B. At presentation, symptoms have generally been present for less than 3 months.
C. The physician should endeavor to curtail the patient's excessive use of medical services.
D. The patient should primarily be seen by a primary care physician, with psychiatric consultation as needed.
E. The possibility of depression, anxiety disorders, schizophrenia, and dementia should be addressed in the hypochondriacal patient.

The correct response is option B (pp. 1547–1548). To meet criteria for a diagnosis of hypochondriasis, older persons must have experienced the disorder for at least 6 months; when most physicians encounter hypochondriacal older patients, their symptoms have lasted far longer than 6 months. Hypochondriacal symptoms in older persons usually are described as being in the gastrointestinal or genitourinary area. The clinician working with a hypochondriacal older patient must be vigilant for the presence of more severe psychopathology. The differential diagnosis includes major depression and dysthymia, anxiety disorders (both generalized anxiety and panic), schizophrenia (if the exaggerated physical concern expressed by the patient borders on delusional thinking), and dementing disorders.

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CHAPTER **38**

Introduction to Cultural Psychiatry

Select the single best response for each question.

38.1 The current scope of cultural psychiatry includes all of the following *except*

A. The relationship of cultural factors to psychiatric illness.
B. The impact of culture on personality development.
C. Collecting syndromes that appear exotic to observers.
D. The impact of culture on social roles.
E. The interaction of culture and psychotherapy.

The correct response is option C (p. 1553; see Table 38–2). The scope of cultural psychiatry encompasses the following:

- Study of people in their natural habitats
- Relationship of cultural factors to specific psychiatric disorders
- Relationship of psychiatric disorders and processes to human universals such as gender and age
- Impact of culture on personality development
- Investigation of culture-bound syndromes
- Comparative studies of diagnostic entities
- Influence of culture on healing systems
- Impact of culture on social roles
- Interplay of culture and psychotherapy
- Impact of race and ethnicity on response to psychotropic medications

38.2 Regarding the International Pilot Study of Schizophrenia (IPSS), all of the following are true *except*

A. Patient-reported symptoms were highly reliable between examiners at the same center.
B. Observed signs were below acceptable reliability ranges.
C. Premorbid patient historical data showed significant cross-cultural variability.
D. Depressed patients with psychotic symptoms were among the most similar of any diagnostic category across cultural groups.
E. The cross-cultural diagnosis of catatonic schizophrenia was more reliable than the cross-cultural diagnosis of paranoid schizophrenia.

The correct response is option E (p. 1559; see Table 38–3). Several conclusions from the International Pilot Study of Schizophrenia (IPSS) merit consideration. Certain symptoms (e.g., phenomena reported by patients, such as hallucinations and delusions) were the objects of greatest interrater reliability, although the reliability was better for raters from the same center than for raters from different centers. In contrast to this finding, the data showed that the rating of signs gathered by observation rather than by self-report, such as flatness of affect or incongruity of affect, was below acceptable reliability ranges. Historical information, such as that having to do with patients' previous level of functioning, personality traits, work history, and social relationships, showed even more cross-cultural psychiatric variability. This work suggested that some cross-cultural psychiatric information might be reliable, although it depended on what type of information one was collecting. Symptoms reported by patients would be a more useful reference point for comparison than signs rated by observers, and premorbid history may be misleading when viewed by a clinician from a culture different from the patient's. Consequently, the cross-cultural diagnosis of paranoid schizophrenia (for which there is substantial reliance on symptomatology) might be more reliable than the cross-cultural diagnosis of catatonic schizophrenia (for which the physician relies on observation of signs).

38.3 Regarding DSM-IV-TR (American Psychiatric Association 2000) and cultural context, the five specified components contained in an explanatory outline for developing a cultural formulation include all of the following *except*

A. Cultural identity of the individual.
B. Cultural explanation of illness.
C. Cultural factors impacting the psychosocial environment.
D. Cultural factors affecting the relationship between the individual and clinician.
E. Focus on the primacy of cultural factors in psychiatric illness.

The correct response is option E (p. 1563). The cultural formulation has five components: 1) cultural identity of the individual, 2) cultural explanations of the individual's illness, 3) cultural factors related to the psychosocial environment, 4) cultural aspects of the relationship between the individual and the clinician, and 5) overall cultural influence on diagnosis and approach to treatment.

38.4 Regarding the syndrome *amok*, all of the following are true *except*

A. It has been associated with Malaya, Papua New Guinea, and Africa.
B. The vast majority of patients are male.
C. There is usually a prodromal period of brooding.
D. The patient is invariably psychotic without a change in level of consciousness.
E. The patient has a sudden onset of uncontrollable rage with violent behavior.

The correct response is option D (pp. 1567–1568). This phenomenon was traditionally associated with Malaya but has been described as occurring also in Africa and more rarely in Papua New Guinea. Often, there is a prodromal period of brooding after an incident during which the victim (almost always male) has felt slighted or humiliated. What follows is a sudden, uncontrollable rage that leads to the individual's aimlessly running around with a weapon that is ultimately used to kill a number of people or animals. Sometimes the perpetrator then kills himself. Those captured alive have claimed no memory of the killing. Although some studies have shown the syndrome to be associated with psychotic disorders, this does not appear to be a uniform finding.

38.5 Regarding the syndrome *koro*, all of the following are true *except*

A. The syndrome occurs either singly or in epidemics.
B. Cases in Asia are generally associated with a malignant course, chronic psychosis, and a poor outcome.
C. An alternative name for this syndrome is *suo-yang*.
D. The patient experiences paniclike symptoms.
E. The patient fears retraction of the genitalia into the abdomen, with resultant death.

The correct response is option B (p. 1568). Various reports from Asia, including Hong Kong, Singapore, India, China, and Malaysia, have referred to the syndrome of *koro*, or *suo-yang*. This syndrome occurs either singly or in epidemics and is characterized by acute and prominent panic-like symptoms brought about by the sudden onset of fear that one's genitalia are retracting into the abdomen and that this will result in death. In contrast, reports from Asia suggest that *koro* presents as a generally benign, time-limited illness without association to additional psychopathology and with a good prognosis.

Reference

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington, DC, American Psychiatric Publishing, 2000

CHAPTER 39

The Law and Psychiatry

Select the single best response for each question.

39.1 In psychiatric malpractice suits in the United States, the most frequent allegation is

A. Medication error.
B. Improper commitment.
C. Incorrect diagnosis.
D. Attempted or completed suicide.
E. Incorrect treatment.

The correct response is option E (p. 1585; see Table 39–1). In an American Psychiatric Association–sponsored review of psychiatric malpractice claims ("Benefacts" 1996), the most frequent allegation was found to be incorrect treatment (33%), followed by attempted/completed suicide (20%), incorrect diagnosis (11%), improper supervision (7%), medication error/drug reaction (7%), and improper commitment (5%).

39.2 The "four *D*s" of medical malpractice include all of the following *except*

A. Duty.
B. Deviation.
C. Damages.
D. Direct causation.
E. Discovery.

The correct response is option E (p. 1586; see Table 39–2). The four *D*s of medical malpractice are Duty, Deviation, Damages, and Direct causation.

39.3 Consent options for patients lacking the mental capacity for informed consent include all of the following *except*

A. Proxy consent of next of kin.
B. Judicial decision of incapacity and appointment of guardian.
C. Institutional administrators or committees.
D. Substituted consent of the court.
E. Advance directives.

The correct response is option B (p. 1590; see Table 39–4). As outlined by Simon (1992), consent options for patients lacking the mental capacity for health care decisions include

- Proxy consent of next of kin
- Adjudication of incompetence, appointment of a guardian
- Institutional administrators or committees
- Treatment review panels
- Substituted consent of the court
- Advance directives (living will, durable power of attorney, health care proxy)
- Statutory surrogates (spouse or court-appointed guardian)

39.4 Common statutory exceptions to psychiatrist–patient confidentiality include all of the following *except*

A. Child abuse.
B. Competency proceedings.
C. Court-ordered psychiatric examination.
D. Imminent danger to self or others.
E. Expressions of anger without criminal intent.

The correct response is option E (p. 1600; see Table 39–6). Common statutory exceptions to confidentiality between psychiatrist and patient include

- Child abuse
- Competency proceedings
- Court-ordered examination
- Dangerousness to self or others

- Patient–litigant exception
- Intent to commit a crime or harmful act
- Civil commitment proceedings
- Communication with other treatment providers

39.5 According to Appelbaum et al. (1987), the standards of mental capacity in decision making include all of the following *except*

A. Demonstration of a score in the "unimpaired" range on formal clinical cognitive assessments.
B. Communication of choice.
C. Understanding of relevant information provided.
D. Appreciation of available options and their consequences.
E. Rational decision making.

The correct response is option A (p. 1602). In order of increasing levels of mental capacity required, these standards are

- Communication of choice
- Understanding of relevant information provided
- Appreciation of available options and consequences
- Rational decision making

39.6 The basic elements of the insanity defense include all of the following *except*

A. Presence of a mental disorder.
B. Presence of a defect of reason.
C. Diminished memory of performing the criminal act.
D. A lack of knowledge of the nature or wrongfulness of the criminal act.
E. An incapacity to refrain from performing the criminal act.

The correct response is option C (p. 1613; see Table 39–10). The basic elements of the insanity defense are 1) presence of a mental disorder, 2) presence of a defect of reason, 3) a lack of knowledge of the nature or wrongfulness of the act, and 4) an incapacity to refrain from the act (Simon 1994).

References

Appelbaum PS, Lidz CW, Meisel A: Informed Consent: Legal Theory and Clinical Practice. New York, Oxford University Press, 1987

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CHAPTER 40

Ethics and Psychiatry

Select the single best response for each question.

40.1 Throughout most of the history of medicine, the emphasis on patient benefit from medical interventions has been described as the age of

A. Patient autonomy.
B. Medical paternalism.
C. Partnership and community.
D. Bureaucratic regulation.
E. Justice.

The correct response is option B (pp. 1629–1630; see Table 40–1). Throughout most of the history of medicine, this paternalistic emphasis on patient benefit has been the central tenet of medical ethics.

40.2 Sanctions by the American Psychiatric Association for misconduct include all of the following *except*

A. Admonishment.
B. Reprimand.
C. Suspension of membership.
D. Expulsion from membership.
E. Direction for state medical board to suspend medical license.

The correct response is option E (p. 1636). The American Psychiatric Association (2001) may impose four possible sanctions for misconduct:

- Admonishment—an informal warning
- Reprimand—a formal censure
- Suspension (for a period not to exceed 5 years)
- Expulsion

40.3 The "upward" perspective (that of the individual moral agent in relation to the larger culture) on the tasks of ethics (as opposed to a "downward" perspective) is characterized by all of the following *except*

A. Moral inspiration.
B. Cognitive.
C. Self-reflective.
D. Teleological.
E. Tacit.

The correct response is option B (p. 1643; see Table 40–6). According to Dyer (1988), the ethical responsibilities can be approached from one of two perspectives. The upward perspective refers to the highest standards of ethical conduct to which a person can aspire; it is affective, self-reflective, teleological (end- or goal-based), fiduciary (trust-based), and tacit. The downward perspective, by contrast, concerns itself with the regulation of abuse and is cognitive, critical, deontological (rule-based), adversarial (control-based), and explicit.

40.4 The functions of ethics in the postmodern (postcritical) account include all of the following *except*

A. Contextual.
B. Personal.
C. Historical.
D. Acultural.
E. Integrity-based.

The correct response is option D (p. 1645, see Table 40–8). Ethics functions in the postmodern (postcritical) account are contextual, historical, cultural, based on integrity, and enforced by willing assent, trust in a convivial order, or community.

40.5 The postmodern medical practice paradigm includes all of the following *except*

A. Chronic illness.
B. Curative interventions.
C. Physician–patient partnership.
D. Population health.
E. Cultural diversity.

The correct response is option B (p. 1645; see Table 40–10). In contrast to the modern medical practice paradigm, which was physician centered and based on acute illness (hospital care), curative treatment, and the individual patient (prototypically young, white, and male), the postmodern paradigm emphasizes the physician–patient partnership and focuses on chronic illness (community care), preventive treatment, and the health of populations (encompassing culturally diverse persons of all ages).

References

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